COLUMBIA LIBRARIES OFFSITE
HEALTH SCIENCES RESTRICTED
HR01206796

SERIAL

V. 14

J

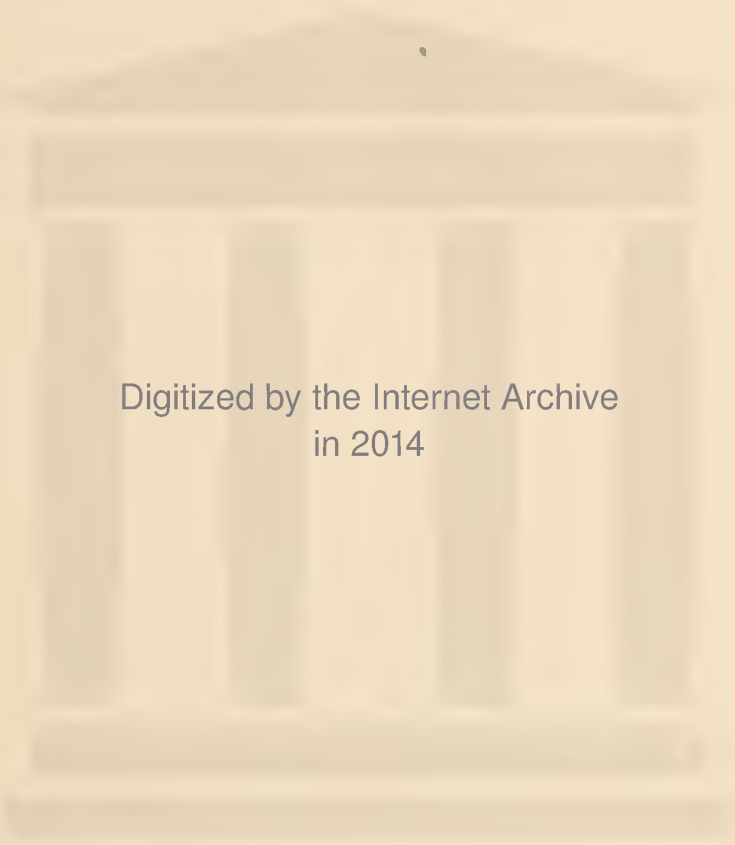
1896

Columbia University
in the City of New York

College of Physicians and Surgeons



Reference Library


Digitized by the Internet Archive
in 2014

https://archive.org/details/journalofcutaneo1418unse

JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES

EDITED BY
JOHN A. FORDYCE, M. D.

ASSISTED BY
JAMES C. JOHNSTON, M. D.

VOLUME XIV

NEW YORK
D. APPLETON AND COMPANY
72 FIFTH AVENUE
LONDON: 33 BEDFORD STREET, COVENT GARDEN

Copyright, 1896, by D. APPLETON AND CO.



DR. HYDE'S CASE OF MYCETOMA.

JOURNAL OF
CUTANEOUS AND GENITO-URINARY
DISEASES.

Vol. XIV. JANUARY, 1896. No. 1.

Original Communications.

A CONTRIBUTION TO THE STUDY OF MYCETOMA OF THE FOOT AS IT OCCURS IN AMERICA.*

By JAMES NEVINS HYDE, A.M., M.D., and NICHOLAS SENN, M.D., Ph.D., LL.D., with report by Dr. D. D. BISHOP, of Rush College Pathological Laboratory.

ON the 26th of September, 1894, W. O. H. was presented at the Surgical and thence referred to the Dermatological Clinic of Rush Medical College. He gave the following history: His parents were both living, though his mother was suffering from some renal affection. Four brothers and four sisters were living, in good health. Three children died in infancy from some cause unknown to the patient, none surviving the first year of existence.

The patient was born in America, seven years after the immigration of his parents from Bohemia, and before his present journey never had traveled outside of his native State. He was twenty years old, a student of dentistry, using tobacco and beer in moderation, and with no venereal antecedents. He weighed one hundred and forty-five pounds, was in general good health, and his functions were all fairly well performed. There were, in fact, no indications of disease beyond the morbid condition to be recognized in one foot.

The present disorder began thirteen years previously, when the patient was seven years of age. At this date he became very fond of wading barefoot with his companions in the Cedar River, near his place of residence in Iowa. At this period of his life he spent most of the summer days thus engaged. Soon after, he noticed a hard nodule,

* Read before the nineteenth annual meeting of the American Dermatological Association, September 18, 1895.

which formed within the skin of the sole of the left foot, and which very gradually spread till an area was involved of the size of a half dollar. This spot was cauterized with nitric acid, and then disappeared for a few years, but later returned and gradually spread till, as now, the anterior third of the left foot was extensively involved in a deformity with tumefaction. The disease is productive of little pain, and he is able to use the foot in locomotion to a surprising extent, considering the degree of its uselessness.

He has been seen by a number of physicians and surgeons, some pronouncing his case one of tuberculosis; others naming it sarcoma. The treatment thus far has been purely local, including the use of iodine and sulphuric and nitric acids. These have proved of no value.

When examined, the anterior two thirds of the left foot were seen to have been converted into a shapeless mass, the tumefaction involving the toes and the dorsal and plantar tissues. The deformity was most marked over the dorsal surface. The mass of morbid tissue represented a bulk considerably larger than that of the normal foot and terminated abruptly and by a well-defined line near the articulation of the metatarsal bones with the tarsus. (See colored plate.)

The tumefied mass had a boggy consistence when handled, and its surface was very irregularly beset with tubercles or, better, fungoid projections from the irregular surface of the infiltrated skin. Each individual papilliform mass was tunneled by one, occasionally by several, fistulous canals, which passed beneath to a softish tissue, the probe not encountering through these channels what seemed to be osseous structure. The greater number of these warty projections varied in size from a small pea to that of a large bean, and were elevated at a corresponding height above the general level. They were massed at the proximal rather than the distal portion of the foot, but were yet irregularly scattered over all its involved surface. A puriform secretion could be expressed from the orifices of some, but none furnished an exudate which might be compared with fish roe, or which had any suggestion of blackness in its color. In fact, the lesions remarkably resembled the small mounds through which the crayfish digs a tunnel, the orifice of which is apparent at the center of his tumulus of earth.

In the present case the central canal perforating the axis of each tubercle or papilloma often seemed blocked by flabby granulations springing from the walls of the excavation. These masses were, however, much softer than the nodules of hypertrophic lupus, and readily admitted an exploring instrument to the fundus of the fistulous excava-

tion. The general color of the diseased portion of the foot was rather grayish than of an inflammatory hue.

The proximal limits of the disease were fairly well defined both on the plantar and dorsal surfaces of the feet at the level of the tarsal extremities of the metatarsal bones. The involvement of the inner as contrasted with the outer face of the foot was marked. Thus the big toe and the adjacent digits were, both on the interdigital, the dorsal, and the plantar faces, much more extensively involved than the little toe and the digit adjoining; and over the inner part of the foot thus outlined the lesions were larger, some of the size of a coat button and more closely set together. The sinuses here were also more obvious, each leading down to the depth of an inch or more to the fascia and sheaths of the tendons beneath. The abnormal convexity of the sole of the foot was distinctly marked. This was most evident in the regions of involvement, the effect being somewhat visibly increased as the result of overuse of the posterior portion of the foot in locomotion. There was hence some swelling of the part of the sole not beset with tubercles, this condition extending slightly upward at the heel as far as the insertion of the tendo Achillis. The nails of the toes were in a gryphotic state, this also most marked in the nails of the first two toes.

Reservation was made respecting the question of diagnosis till microscopical examination of the tissues had been completed, the attention of the class present being directed to the strong resemblance of the member to Madura foot, due reserve being made in view of the fact that the subject of the disease was a native of America and had never visited another country.

A piece of the morbid tissue, having been excised, was submitted to examination. Two guinea-pigs were also inoculated with material taken from a discharging sinus, the result being that one died in the course of four days, the autopsy revealing nothing as to the cause of death. As we have since discovered that the effective fungus of the disease is deeply buried beneath granulation tissue, we think no inferences can be drawn from these facts.

The patient after this experience returned to his home and in the course of a few weeks came again to Chicago and underwent amputation of the leg in the lower third by Dr. Senn. We examined him with care about eight months after the date of the amputation, on the 14th of June. At that time he was a picture of sound health, and was walking with ease by the aid of an artificial limb.

The amputated member was examined in the Bacteriological Laboratory, Dr. Bishop subsequently reporting on the pathological conditions present as follows:

Gross Appearances.—Distributed over the dorsum of the foot, particularly the tarsal and metatarsal regions, the toes, and to a less extent upon the plantar surface, numerous spongy nodular projections, half pea to hazelnut in size. Most of the nodules show one or more openings at their summits.

Section through the nodules and underlying part brings to view a spongy reticulated tissue, fairly well circumscribed, at times having a rather dense fibrous wall. These collections of spongy tissue are easily traceable down to the periosteum of the underlying bone. The periosteum is very much thickened, but at certain points presents a reticulated appearance, identical with that observed in the softer tissues.

Longitudinal section of the first metatarsal bone brings to view two small rounded areas, one the size of a pea, the other slightly larger, both filled with a whitish, granulationlike tissue. These collections are surrounded by a firm fibrous capsule which is easily separated, leaving a smooth-walled cavity in the bone. They are situated just beneath the periosteum and communicate with the reticulated meshwork in the latter. The rest of the osseous structure appears more spongy than normal.

On pressure over the soft tissues, numerous whitish, small pinhead-sized bodies escape from the meshes of the reticulum; and scraping of the whitish collections in the bone removes similar bodies.

Microscopic Examination.—One of the smaller and presumably younger nodules, with no demonstrable external opening, was hardened in alcohol, imbedded in celloidin, cut, and stained with Delafield's hæmatoxylin and aqueous eosin solutions. The general appearance given by such sections is that of rather active inflammation. As to the epidermis, the intercellular spaces, especially in the superficial layers (but in places reaching into the rete mucosum), are considerably enlarged. Here and there are widely open spaces in which the rete cells are drawn out into long strings. Granular deposits in these spaces are often seen, suggesting the presence of a serous exudate. Leucocytic infiltration between the epidermal cells has also taken place. The membrana propria seems undisturbed.

In the derma, and more deeply situated, are bodies having a raylike appearance; these were found in all the nodules examined (Fig. 1). These bodies consist of more or less rounded masses, often having a scalloped border. They occur singly and in groups. In all there is a central area which stains faintly with hæmatoxylin; surrounding this, a zone which also stains deeply with the same dye; and outside of all, a narrow margin staining with eosin only. These three divisions of the fungus may be called, as suggested by Kanthack, in his descrip-

tion of mycetoma, the central area (1, Fig. 2), the marginal zone (2, Fig. 2), and the radial zone (3, Fig. 2).

When examined with an oil immersion, $\frac{1}{12}$ inch lens and No. 3 eyepiece, Leitz, the central area appears granular, but shows a few delicate filamentous threads, resembling long, slender bacilli, having an obscure radial arrangement. In the marginal zone are seen numer-



Fig. 1.—Photomicrograph to show groups of organisms and surrounding leucocytic infiltration, from a section stained faintly with eosin and hæmatoxylin. Spencer half-inch, Zeiss projection ocular 4, × 200.

ous long, deeply staining threads, having a distinctly radial arrangement. These are also very slender and stain best at the periphery, giving the appearance of a fine mycelial network. The radial zone is separated from the marginal zone by a narrow space, which stains scarcely at all, and which appears in the main to be granular (6, Fig. 2). A few delicate threads, however, may be traced through this light area, connecting the marginal and radial zones (8, Fig. 2).

The radial zone, when observed with a Zeiss apochromatic 2·0 mm. eyepiece 8, appears granular in most of the sections, but in well-prepared specimens one can make out distinctly radiating lines, giving an appearance of more or less wedge-shaped bodies closely packed together, with their broad ends presenting peripherally. These radiating lines, suggesting in appearance the rays of actinomyces, are, it is true, difficult of demonstration; but after a careful study of a large number of specimens I am convinced of their presence. Most

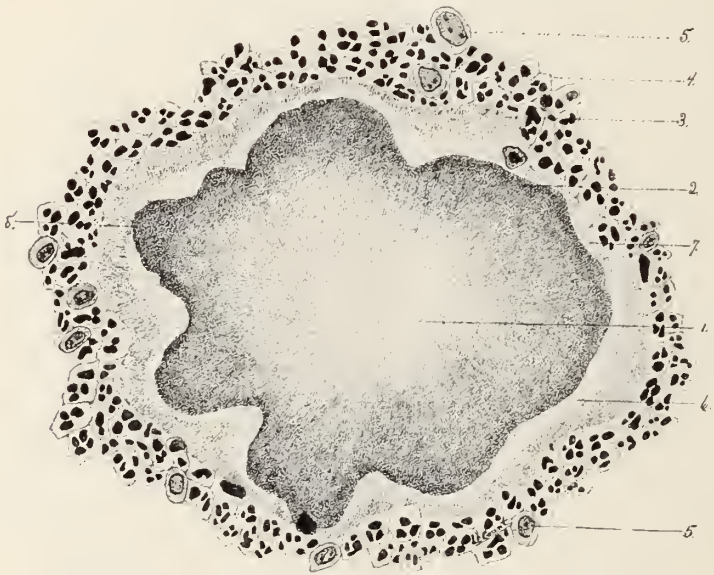


FIG. 2.—Drawing of a single micro-organism and zone of leucocytic accumulation. Camera lucida, diameters 810, reduced one third; objective, one-twelfth-inch oil immersion, eyepiece III (Leitz). Specimen fixed in Flemming's solution and stained with aqueous methylene blue. 1. Central area. 2. Marginal zone. 3. Radial zone. 4. Polynuclear leucocytes. 5. Embryonal cells. 6. Light area between marginal and radial zones. 7. Point of invasion of radial zone by leucocytes. 8. Mycelial threads extending across light zone (6).

of the features here described are shown in the carefully executed drawing forming one of the illustrations of this paper, and made by Dr. E. R. Le Count, of the Rush Pathological Laboratory.

Careful search failed to disclose the presence of any of the larger club-shaped bodies described in connection with such fungous growths, nor was I able to demonstrate any branching of the mycelial threads. Again, no distinct evidences of segmentation were observed; in specimens, however, prepared by Weigert's fibrin stain, the radiating filaments appear as rather long bacilli, now and then meeting at their

ends, suggesting a division of such threads. The same appearance was noted by Kanthack in his sections, stained with a modification of Gram's method, but it was looked upon by him as an effect produced by the method employed.

The Tissue Changes.—Immediately surrounding the fungus is a wide zone of deeply staining polymorphous nuclei, plainly leucocytes (4, Fig. 2). In sections from the larger and presumably older nodules, these cells are seen to have involved the radial zone (7, Fig. 2). The surrounding tissues show numerous newly formed blood-vessels; other better formed vessels distended with blood-corpuscles are seen, and in many a well-marked proliferation of endothelia has occurred. The vessel walls are often infiltrated with proliferating connective-tissue or endothelial cells. Leucocytes and epithelioid cells are also abundant in the rather large connective-tissue spaces. Here and there giant cells are seen, at times with peripherally arranged nuclei like those of general occurrence in tuberculosis; again, other forms are seen in which the nuclei are more diffusely distributed throughout the cell body. Granular material staining with eosin, so commonly present in œdematous tissues, is often present in the connective-tissue spaces. The connective-tissue fibers are apparently increased in number, but there is no encapsulation of the fungus.

Microscopic sections through the larger nodules show sinuses lined with granulation tissue extending down to the abscesslike formations. Serial sections failed to demonstrate any relationship between the growth of organisms and the blood-vessels. None of the individual filaments or rays was seen in the tissues remote from the main growth. With Weigert's fibrin stain the mycelial threads were deeply colored, appeared rather broader than with the other dyes, and as before shown were broken into short segments. With Gram's stain they were decolorized. Flemming's hardened sections stained with aqueous methylene blue brought out the mycelial threads very clearly; safranine was also successful, but none of these basic dyes stained well the radial zone.

Although the tissues were examined carefully in the fresh state, the fish-roelike particles described as occurring in mycetoma were not seen; numerous small whitish bodies, already described, were easily pressed from the cut surface of the lesions, but these were never larger than a small pinhead. When carried to a slide and mounted in the preservative fluid or washed with water and soaked in liquor potassæ these small bodies appear under the microscope as rounded objects with a mulberrylike surface. The center of these bodies is dark and granular, but the surface is covered with a more transparent coating

in which an obscure radial striation can be demonstrated. The same appearances were seen in similar particles removed by scraping the granulations in the bone. In none of these, however, were typical clubs seen.

Reviewing the appearances as a whole, we find surface nodules and infiltrating deposits in the deeper tissues and bones, composed of granulation tissue, containing here and there organisms in which mycelial filaments are easily demonstrated, and possessing indistinct rays arranged around the periphery. The general characters of the organism resemble those seen in actinomycosis, but correspond more closely to those described in mycetoma.

The pathological study of mycetoma is almost limited, as to time, by the experience of the modern disciple of dermatology. The fungus originally recognized in the black variety of Madura foot by Vandyke Carter was by him later regarded as probably identical with actinomycosis, and to which the disease was then attributed. Less than ten years ago Ponfick, Crookshank, Kanthack, Hewlett, Boyce, Vincent, and others began to investigate this remarkable resemblance. As, however, this resemblance was more clearly recognized, the noteworthy differences between the two diseases have become accentuated, the result to-day being some little confusion. No attempt can be made, based upon the results of examination of a single case, to decide definitely on the question of the identity or absolute diversity of the two maladies under discussion. The subjoined points of distinction, however, are fairly well illustrated both in the literature of the two diseases and in the examination of the case here recorded. Some of them have been already formulated by Surveyor.

Madura foot is apparently a purely local disorder; in the many cases on record no history occurs of cervical or thoracic complications as in actinomycosis; mycetoma chiefly attacks the feet and hands, occasionally the ankles and knees; in India, where it is prevalent, actinomycosis is almost unknown; and the commoner cervical localizations of actinomycosis are never the sites of mycetoma. There are no black, red, and white (or pale) varieties of actinomycosis as in mycetoma, though upon this point it is to be admitted that there is a possibility that the appearance of the black grains in one variety of Madura foot is due either to an accidental change in the fungus, or, as has been suggested, to a double infection.

Respecting the fungus of mycetoma and that of actinomycosis the following differences are set forth by Surveyor and Boyce: actinomyces grows readily in a hydrogen atmosphere; the fungus of mycetoma grows in such an atmosphere, but only with exceeding slow-

ness; it also differs in the rapidity with which it takes up aniline stain.

The following unsettled points indicate how far we are at present from understanding the exact nature of these diseases and their mutual relations: (1) There is no agreement as to what constitute the differences between the white (or "ochroid"), the red, and the black varieties of Madura foot. These different clinical symptoms, it is to be noted, are never in any one instance commingled, so that the granules at one time black are at another red or white. (2) In some cases where the fish-roelike particles have been surgically evacuated from sinuses existing in unquestioned subjects of Madura foot, no fistulous tracts have opened externally to the outer surface of the skin. In several unmistakable cases of Madura foot, where no doubt existed as to the clinical symptoms, no fungus whatever has been detected.

Aside from the light thrown upon the nature of the morbid process by microscopical examination of the tissues, the gross appearances of the organ in the case here described were certainly such as to suggest at a glance the familiar outlines and special deformity of the Madura foot. The involvement of a single foot, the mamelonated projecting tubercles, each tunneled to a sinus extending to the deeper tissues, and the thin character of the discharge from each, were all of classical type. Exclusion of the black variety of podelcoma was readily effected on a first examination.

The history of this case is nearly in the line of those of a similar sort thus far recorded. The exposure of the bare foot to the sources of the disease by wading in watercourses, the slow onset of the malady, at first localized in a minute nodule in the sole, and the chronic evolution of the disease in years are noticeable features. The period of time required to produce the degree of deformity present in this case, viz., ten to thirteen years, is less than others on record in which twenty and even thirty years have elapsed before the subject of the disease came under observation. In the present case the bulk of the foot, though much less than in some of the formidable cases seen in India, presents a deformity of the dorsum and sole in strict conformity with the outlines usually recognized in Madura foot. Its occurrence in the male by preference can, I believe, be satisfactorily explained by the more frequent exposure of barefooted men in the beds of watercourses, though the disease has been also produced by tramping with the bare feet in the fields, and the traumatism of these members by thorns.

The commonly accepted title of the Indian disorder, viz., Madura foot, has perhaps contributed to the general belief that the disease ex-

ists in India only. Cases, however, are on record of its occurrence in Africa, in Syria, in Europe, and in other countries.

The only recorded instance of the production of Madura foot in America accessible when these pages were first written was that given by Kemper, in the *American Practitioner* of September, 1876. One of us (J. N. H.) has published briefly detailed observation of a case of podelcoma occurring in the practice of our late colleague, Prof. Charles T. Parkes, of Chicago. During his lifetime these details were obtained from a verbal description of the symptoms exhibited by the patient, and the features of the disorder were without question those of true mycetoma. As the subject of the malady, however, had been a resident of India, the case has no bearing on the history of Madura foot in America. A brief abstract of Kemper's case is subjoined for the purpose of comparison:

The patient was a native of Ohio, twenty-four years old, and by occupation a clerk. There was no history of venereal disease. In December of 1875 the right foot became swollen, reddened, and painful, this condition persisting till the following April, a period of but four months, and it is noticeable that in three weeks from the date of the onset of the disease there had been involvement of the entire sole.

Subsequently "blebs" appeared, in number five or six, and ranging in size from a split pea to lesions with a diameter of half an inch. Each bulla had a centrally situated opening from which issued a non-purulent, foul-smelling secretion, resembling the white of an egg. Gradually ulcers formed and spread by extension till they were separated only by bridges of undermined integument. They finally fused until a single large ulcer formed on the inner side of the foot, with two smaller and similar excavations in the neighborhood.

The subsequent history is chiefly descriptive of the intense grade of pain experienced by the patient, and the exquisite sensitiveness of the affected foot which resented the slightest degree of pressure. Hypodermic injections of morphine and even anæsthesia were tried without effective results. On the 16th of June, six months after the onset of the malady, relief was secured by amputation, and this was followed by satisfactory healing of the stump.

The report of the gross and microscopical appearances includes a description of a "white, fluffy substance" visible to the naked eye upon the surface of the ulcerations. The fistulous channels were found to lead to muscular tissue. Microscopically, rough, irregularly outlined, yellowish, and refractive granular bodies were recognized, and these were supposed to be the spores of a vegetable fungus.

In the following points it will be seen that the symptoms given

above are wholly different from those of mycetoma as it is described by Indian authorities:

1. The process was manifestly of an acute type both in the matter of time and of severity of symptoms. In a series of recently reported Oriental cases none exhibited any characteristically developed deformity in so brief a period of time as three weeks, and none had advanced to a state requiring surgical interference in six months. 2. The pain experienced by Kemper's patient is wholly absent in the enormous majority of all Indian cases. The subjects of the disease are usually found pursuing their vocations, and consent to removal of the offending organ chiefly because of its bulkiness and unwieldiness. In the case of our patient, locomotion by the feet had been steadily practiced for years, and he informed me after the amputation and the adjustment of an artificial limb, that with this member he walked no better than with his tumefied foot, the chief advantage of the former being its appearance. 3. In Kemper's case the external lesions are described as bullæ surmounting sinuses, a description consistent with the acuity of the process illustrated by other symptoms. In most of the subjects of mycetoma, however, the lesions are of the order of those recognized in the Iowa patient—viz., tubercles, nodes, warty and papillomatous elevations of the surface, indolently formed and scarcely changed for years after the central channel has penetrated to the deeper tissue. 4. The occurrence of distinct ulceration in Kemper's case, and the relatively rapid extension of the destructive process, as a result of which fusion of contiguous ulcers occurred, forming thus a large loss of continuity, are rare features when the foot is involved in mycetoma. Lastly, the occupation of the subject of the disease was not such as to render it probable that he had exposed his bare feet to the sources of the disease. Kemper's patient was a clerk, and the acuity of the symptoms forbids the supposition that he had been affected for years before the onset of his malady. Some, however, of the Oriental subjects of the disease pursued occupations usually practiced within doors in this country but in other lands often in the open air—as, for example, barbers, weavers, shoemakers, and blacksmiths.

In view of the facts detailed it would seem that, apart from the failure to recognize radiating hyphæ in the tissue examined, Kemper's case can only with great reserve be accepted as an illustration of mycetoma occurring in America.

The following conclusions are based upon a study of the case here described, as well as upon reports of Indian observers published within the last two years:

There are clinical symptoms of mycetoma which are to be recog

nized in some cases and not in others. These may be termed non-essential features of the malady. They are: (*a*) the appearance of blackish or reddish granules of pigment, free and within the cells furnished by the secretion; (*b*) the discovery of particles resembling the roe of fish, either expelled from the sinuses or imprisoned within the unbroken surface of the skin; (*c*), the occurrence of sinuses leading from without inward as far as muscle, tendon, or blood-vessel. Cases of unquestioned mycetoma are on record where none of these features was exhibited.

The constant symptoms of the Madura foot are practically reduced, then, to a characteristic deformity of the affected part, predominantly the foot, and in men; but also the hand, shoulder, knee, and a few other regions in the two sexes, and the discovery of a radiating fungus. With the deformity there is a tolerably constant history of a slowly progressing involvement of the tissues; and, when the feet are affected, of exposure of the subject of the disease barefooted, in the beds of watercourses or in the open fields. There is further a notable absence of complaint of pain, of occurrence of relatively acute symptoms, and of the accidents commonly complicating elephantiasis of the lower extremities, such as, for example, recurrent attacks of lymphangitis, of erysipelas, of eczema, or of furunculosis.

The essential microscopical features of the disease in its several forms can not be classified accurately in the present state of our knowledge of the subject. There should be recognized a septate vegetable fungus set in granulation or necrotic tissue with a number of unusually large giant cells which seem to be exercising a phagocytic effect upon the intruder. The several forms displayed by the vegetable growth, in consequence of its highly pleomorphic variability, differ not only in different cases, but in different stages of development, and in different infected animals. It is this feature which up to the present time seems to have furnished such widely different pictures that it is not to-day known whether actinomycosis and the several varieties of mycetoma are produced by one or more varieties of a single fungus or by wholy differing organisms.

In well-marked cases of mycetoma there is usually a central body or mass made up of semilunar or reniform bodies, traversed by a network of mycelium. The hyphæ exhibit the widest variation, being at times long and slender; at others, short and "dwarfed"; and again spherical in shape rather than elongated. In other cases no mycelium can be recognized. The "clubs," of which so much has been detailed by the earlier writers, are often wholly wanting, and at other times are evidently rudimentary as to their formation. They are be-

lieved to be produced by the reactionary processes of the tissue against the presence of a foreign element—the process, in fact, which accounts for the presence of unusually large giant cells in the necrotic tissue. The radiations from the central bodies forming a definite zone, the nature of which is not fully determined, seem to be a tolerably constant feature of mycetoma, and are readily distinguished in the sections made from the foot furnishing the basis of this contribution. Lastly, the fungus burns with a luminous flame, the incinerated ash having the odor of burnt feathers and a shade of color supposed to be due to the presence of iron.

When the manuscript was preparing for the pages which preceede, the authors were not aware that Prof. J. G. Adami, of McGill University, Montreal, had reported, and but a brief time before printed his report in the *Transactions of the American Association of Physicians* for 1895, a case of Madura foot occurring in America. Attention was called to the fact when one of us (J. N. H.) presented a report of our case to the American Dermatological Association, meeting in the city of Montreal, in September, 1895. Prof. Adami at that time kindly exhibited to the reader the bones of the foot amputated in the case of his patient, and also examined sections of the tissue stained and mounted in Chicago. He was also shown the original drawings of the foot seen in the accompanying illustration (Fig. 3), and fully recognized the identity of the disease in the two patients.



Fig. 3.—Lesions shown in Prof. Adami's case of mycetoma.

Prof. Adami and his colleague, Dr. Kirkpatrick, are entitled to the credit of observing and publishing the report of the first undoubted case of mycetoma occurring on the American continent. The Iowa case, now reported, is probably the first of occurrence in the United States. A brief abstract of the Canadian case is herewith appended:

The patient was a French Canadian, twenty-one years old, and a native of Montreal, who had never been away from Canada. There was no history of tubercnlosis in his family. A bluish spot appeared on the inner side of the right foot at the eleventh year, slowly increasing to the size of a small coin. Then followed a history of traumatism and disappearance of the plaque; occurrence of another lesion, described as a *bouton de chair;* later, disappearance also of this last, followed by the formation of a sinus; later, a second traumatism, followed by swelling and tenderness of the foot, but the disorder was throughout painless, as in our case, and as distinguished markedly from that of Kemper. Eventually the foot was studded with buttons, generally discrete, occasionally grouped, most extensively developed on the dorsum of the foot, but seen elsewhere, subpedunculated when isolated, each representing a cutaneous overgrowth of low vitality and pinkish or bluish-pink in color. A few had closed, and in the site of such a cicatrix formed. The sinuses led to carious bone, and the entire tissue was riddled extensively with these fistulous tracts. The bones were in a carious state and affected with a rarefying osteitis. Some of the articular faces were destroyed. Radiating osteophytes were recognized on the cutaneous surfaces of the scaphoid and internal cuneiform bones.

Prof. Adami was able to express from some of the sinuses pinhead-sized and larger yellowish-gray granules, their appearance in general being identical with that of the ray fungus, forming lobate-reniform masses with a central dense mycelium and a radiate arrangement of filaments or clubs at the periphery, larger than those of actinomyces and bifurcating. These were surrounded by leucocytes. Some of the separated hyphæ showed evidence of being formed of joints, varying in length and breadth; but Prof. Adami concludes (a conclusion confirmed in a personal communication made later to one of us, J. N. H.) that these segmented hyphæ are an intrusion, and that the sinuses contained more than one variety of fungus.

RECENT BIBLIOGRAPHY.

Adami, J. G., and Kirkpatrick, B. A. Notes upon a Case of Madura Foot occurring in Canada. Reprint *Transactions of the Association of American Physicians*, 1895.

Bassini. *Arch. per la Sci. Med.*, xii, No. 15, p. 309.

Bocarro, J. E. Mycetoma. *Indian Medical Record*, Calcutta, 1893, v, 1, 74, 106, 148, 214.

Further Clinical Notes and Remarks on Mycetoma. *Indian Medical Record*, vi, 1894, 332–334.

An Analysis of One Hundred Cases of Mycetoma. *Lancet*, London, 1893, ii, 797.

Clinical Notes on Mycetoma, differentiating the Pale and the Black Variety. *Indian Medico-Chirurgical Review*. Bombay, 1894, ii, 893–896.

Boyce, R. W. Eine neue Streptothrixart gefunden bei der weissen Varietät des Madurafusses. *Hyg. Rundschau*, Berlin, 1894, iv, 529–531.

Boyce, R. W., and Surveyor, N. F. Upon the Existence of More than One Fungus in Madura Disease (Mycetoma). (8vo, London, 1893.) Cutting from *Proceedings of the Royal Society of London*, 1893, liii, 110–112.

Madura Disease. 8vo, London, 1893. Reprint from *Lancet*, London, 1893, i.

The Fungous Foot Disease of India. *British Medical Journal*, London, 1894, ii, 639.

Carter, Vandyke. On Mycetoma, London, 1874. *Bombay Medical and Physiological Society*, 1886.

Gemy and Vincent. *Ann. de Derm. et de Syph.*, Paris, 1893.

Hatch, W. K., and Child, F. L. A Remarkable Case of Mycetoma. *Lancet*, London, 1894, ii, 1271–1273.

Hewlett, R. T. On Madura Disease (Mycetoma) of the Foot. *Transactions of the Pathological Society of London*, 1892–'93, xliv, 172–177, illus., one plate.

Hyde, J. N. A Practical Treatise on Diseases of the Skin. Second edition. Philadelphia, 1888, p. 496.

Kanthack, A. A. Madura Disease (Mycetoma) and Actinomycosis. *Journal of Pathology and Bacteriology*. Edinburgh and London, October, 1892, i, 140–162, three plates. *Lancet*, January 21, 1892, i, p. 195. *Journal of Pathology*, 1893, i, p. 140.

Kemper, G. W. H., and Jameson, H. A Case of Podelcoma. *American Practitioner*, September, 1876, p. 577.

Koebner. *Arch. f. Derm. u. Syph.*, 1891, p. 843.

Le Dantec. Étude bactériologique sur la pied de Madura du Senegal. *Arch. de méd. Nav.*, Paris, 1894, lxii, 447–454.

Ruelle, E. Contribution à l'étude du mycetoma. 4to, Bordeaux, 1893. (Thesis.)

Shah, T. M. Mycetoma; Varieties, its Clinical Aspects; with Cases. *Medical Reporter*, Calcutta, 1893, ii, 225–227.

Surveyor, N. F. Madura Foot of India. *British Medical Journal*, London, 1892, ii, 575.

Vincent, H. Étude sur le parasite du "pied de Madura." (At bindery.) *Ann. de l'Inst. Pasteur*, Paris, 1894, viii, 129–151, one plate.

A REMARKABLE CASE OF PURPURIC ERUPTION ENDING IN GANGRENE, APPARENTLY CAUSED BY SODIUM SALICYLATE.*

BY FRANCIS J. SHEPHERD, M. D.,

Surgeon to the Montreal General Hospital, and Lecturer on Dermatology, McGill University, Montreal.

HAVING had under my care during the past summer a very unusual case of skin eruption, supposed to be caused by the ingestion of sodium salicylate, I thought a report of it would interest the members of this association. I am indebted to my house surgeon, Dr. Byers, for the careful notes taken of this case.

William B., hotel porter, aged thirty-two, was admitted into the Montreal General Hospital, May 8, 1895, complaining of pain and swelling in the left knee-joint. Patient is a well-made man of medium stature, somewhat addicted to alcohol. Had typhoid fever six years ago, and a year later several severe attacks of renal colic, for which nephrotomy was performed. He never had syphilis, gout, or rheumatism. Two days before entrance into hospital, had received a severe blow on the knee, which was followed almost immediately by swelling, pain, and heat in the joint.

On examination the left knee exhibited all the characteristics of an acute synovitis. As there was no history of gonorrhœa or any other condition tending to a synovitis, the diagnosis of traumatic synovitis was made and appropriate treatment adopted. With the exception of the knee-joint lesion the patient was perfectly healthy.

The next day after admission the patient's temperature, which had previously been normal, rose to 100° F., but there was no aggravation of the knee symptoms.

Three days after entrance the heat, swelling, and pain disappeared from the left knee, but now the right knee was becoming affected. It was slightly swollen, red, and very painful. Thinking the case was one of acute rheumatism, and waiting his transference to the medical wards, the house surgeon ordered twenty-grain doses of sodium salicylate to be taken three times a day. After three doses had been taken (one drachm), an eruption appeared on the body and extremities looking very much like urticaria. Distinct wheals were seen, but there was not much itchiness. Successive crops of these urticarial spots coming out, the administration of the drug was discontinued.

* Read before the nineteenth annual meeting of the American Dermatological Association, September 18, 1895.

The spots now became petechial, and were raised above the surface and considerably indurated (Fig. 1). The spots went through the usual chromatic changes following extravasation of blood, and coincidently



Fig. 1.

the induration altogether disappeared. At a few points the hæmorrhagic extravasation was so great that the vitality of the skin was

destroyed, and a deep slough resulted, which on separating left a well-marked ulcer which was very slow to heal. The eruption affected all superficial parts of the body except the palms of the hands and soles of the feet. In addition to this the mouth, soft palate, tongue, pharynx, and larynx were all the seat of the eruption, which caused a great deal of œdematous swelling and led to alarming symptoms of impending suffocation, and for some days the patient was unable to swallow anything but liquid food, and that in only very small quantities. Myalgic and arthralgic pains accompanied the eruption The heart was normal throughout the course of the case, and once only was a trace of albumin found in the urine. There was never any blood or pus in the urine, nor was there any disturbance of the bowels. The whole period occupied by the disease from the onset to the disappearance of the eruption was thirty-three days.

Such is the general account of the case, as to the distribution of the eruption and its appearance.

As was noted, almost every part of the surface of the body except the palms of the hands and the soles of the feet was affected at some time or other during the course of the disease. The eyelids were so swollen that the patient could not see out of his eyes, and the prepuce was much enlarged, discolored, and œdematous. The tongue, mouth, and pharynx were similarly affected, large extravasations occurred in the soft tissues of the palate and pharynx, and many sloughy spots were seen as the result of the severe hæmorrhage. This gave rise to difficulty and severe pain in swallowing. The larynx, owing to the condition of the mouth, could not be examined with the laryngoscope, but the voice was much altered and severe dyspnœa occurred at times, showing that the conditions existing in the mouth were also present in the larynx.

The eruption first appeared on the right leg, thigh, left leg, and left elbow. Then the trunk became affected, and the backs of the arms, the face, and mouth. The shoulders next were the sites of the eruption, and here it was more severe than anywhere else (Fig. 2). About the neck, shoulders, and upper arms the extravasation following the urticarial wheals was so great that large sloughs were formed. The eruption was much more extensive on the posterior than the anterior surface of the body. The scapular region and nape of the neck, backs of arms, back, buttocks, backs of thighs, and calves of legs were especially affected; indeed, in every part where there was much pressure the rash was thickly distributed. On the anterior surface the only parts affected were the face, upper part of thorax, shoulders, thighs, and dorsum of right foot, and in no place was the eruption very abun-

dant. Over the shoulders and arms the eruption was most violent, the extravasations leading to necrosis of the skin. Several crops of eruption came out from time to time, but none was so severe as the first.



Fig. 2.

When the spots first came out they had exactly the appearance of urticaria, the wheals varying in size from a ten- to a fifty-cent piece and elevated above the surface of the skin. At times they were slightly itchy, and the patient complained of stinging sensations. Soon after their appearance the spots became markedly infiltrated, and the surrounding tissue was slightly œdematous. In some regions, the arms especially, the swelling was acute and associated with tenderness and pain, probably due to the tension. Within twelve hours the infiltrated

spots showed blood extravasation. They had at first a pinkish color, with here and there a central spot of a darker shade. In some instances the whole spots became dark from extravasated blood. In another forty-eight hours the infiltration had disappeared, and the color changes in the spots had commenced. These were very striking, the body being covered with brown, red, and coffee-colored spots. In many places, where several wheals had run together, a large, irregular, sharply defined spot was seen. The extravasated blood in the greater proportion of the eruption was rapidly absorbed, and the spots gradually disappeared, going through the various color stages of a bruise; but in certain places, instead of the extravasation being of moderate extent, it continued to increase and finally destroyed the part, forming deep sloughs, which slowly separated from the tissues below. This local gangrene, which occurred in the mouth and pharynx as well as on the surface, was most marked about the right and left shoulders and upper arms. In these latter spots the process was very rapid. First, large, irregular, and raised patches were seen, much indurated and very painful. These patches were in size from a fifty-cent piece to the palm of the hand, the larger patches being due to the fusion of several smaller ones. The central portion was of a dark purplish color, fading gradually to bright crimson, pink, and pale pink. The tenderness and pain as well as the inflammatory areola were marked. Later, the central portions of the spots became quite black, and blebs appeared on the surface, and soon a line of demarcation formed, and the dead began to separate from the living. During the separation of the sloughs the patient had a rise of from two to three degrees of temperature and felt ill and miserable. As the sloughs separated, his condition improved, and he was discharged from the hospital about the middle of June, with healthy granulating ulcers, which were dressed from time to time, and did not completely heal until September last. The patient has had no pain in joints and limbs since leaving hospital. That salicylate of sodium is the cause of skin lesions is well known. After the administration of this drug the appearance of erythema or urticaria has been frequently noted; in some cases intense itching has been the chief symptom, and cases of œdema of the eyelids following its use have also been reported. Freudenberg (*Berlin. klin. Woch.*) reports a case in which a petechial eruption occurred after the taking of five grammes (seventy-five grains) of sodium salicylate. These petechiæ were intensely itchy, and some were the size of a fifty-cent piece. They occurred on the back at first, but afterward spread to the breast, shoulders, upper arms, hips, and thighs. After eight days the spots became paler, and the epidermis desquamated in large scales.

Of course, some might contend that my case was not one of drug eruption, but one of those rare forms of peliosis rheumatica known as erythema purpuricum. Hutchison calls it purpura thrombotica. In some of these cases the hæmorrhage is severe enough to destroy the skin and cause a slough. It is said that the rash of this affection occurs chiefly in the legs, and is more often seen in women.

The pains in the limbs, the swellings in the joints, and the duration of the case would perhaps render this diagnosis probable, but still the fact remains that until the drug was administered no sign of any skin affection was seen, and the purpura was preceded by a well-marked urticarial rash. Again, the hæmorrhagic condition existed in the mucous membranes or under the skin. Still, there is no doubt much to be said in favor of the diagnosis of peliosis rheumatica, and since the case occurred I have been daily more inclined to come to the conclusion that the eruption was not due to the sodium salicylate alone.

CASE OF DOUBLE LIGATION OF THE VASA DEFERENTIA FOR HYPERTROPHY OF THE PROSTATE.

By F. TILDEN BROWN, M. D.,
New York.

T. McB., aged seventy, male. Ireland. Married. Cabdriver. Admitted to Presbyterian Hospital, June 22, 1895; discharged August 27, 1895. Cured.

Previous History.—Had never had rheumatism, syphilis, or malaria. Had, when young, a short attack of gonorrhœa. For the past nine or ten years he was troubled with frequent urination. Five years ago he had a sudden attack of retention, with constant dribbling, which yielded to Sitz baths, rest, and catheterization. Afterward involuntary dribbling from overdistention troubled him at times, and frequency was greater than it had been before.

Present Illness.—Two weeks ago on getting up he was unable to pass any urine. He was treated for five days, as on the previous occasion of retention, without improvement of his symptoms, and then sent into the hospital.

On admission, complains of inability to pass a drop of urine. Temperature, 98·2°; pulse, 96; respiration, 18. Urine acid; shows a moderate trace of albumin, some pus, and muco-purulent shreds; no casts. Lungs emphysematous. Rectal examination shows a rather symmetrical enlargement of the prostate, suggesting the size of a billiard

ball. Bladder examined negatively for stone. Meatus urinarius admits only 17 F. instruments. No difficulty in passing such sized instruments through the prostatic urethra.

Treatment.—Regular catheterization, rest in bed, light diet.

July 2d.—Meatus and fossa navicularis incised so as to admit instruments of 32 F. caliber to the bladder, thinking it possible that this might react favorably upon the condition of complete retention if the cause resided in the posterior urethra. During the next ten days the patient was kept in bed and regularly catheterized with a gum silk in-



Patient during the third week after double ligation passing urine voluntarily.

strument of 30 F. There was not the slightest improvement, and all the most careful observation pointed to the hypertrophied prostate as the reason for his retention.

On July 11th ten minims of a four-per-cent solution of cocaine was injected into the tissues overlying the spermatic cords close to the external abdominal ring.

The vasa deferentia was separated to the extent of an inch from the cord, and double ligatures of fine silk a quarter of an inch apart placed on each vas. The vas was not severed. Wounds were closed with con-

tinnous fine black silk suture, and covered with the usual iodoform gauze dressing. The patient was returned to bed and kept under the same conditions as those pertaining before the operation. Until July 18th, seven days after the operation, all urine was passed through a catheter. On this day a few drops, estimated as two drachms, were passed voluntarily. From this date until he was discharged as accurate measurements as was possible were kept of the quantities of urine passed through the catheter and the urethra respectively.

	By catheter.	By urethra.	Greatest amount of residual urine found at any time each day after voluntary micturation.
July 19	All.	0 ounces.	
" 20	"	0 "	
" 21	32 ounces.	2 "	
" 22	24 "	11 "	
" 23	49 "	3½ "	
" 24	28 "	5 "	
" 25	31 "	10 "	
" 26	28 "	12 "	
" 27	41 "	20 "	
" 28	23 "	15 "	
" 29	29 "	25 "	12 ounces.
" 30	13 "	29 "	6 "
" 31	13 "	27 "	5 "
Aug. 1	5 "	28 "	5 "
" 2	9 "	39 "	9 "
" 3	5 "	42 "	5 "
" 4	7 "	31 "	7 "
" 5	Catheter not used.	43 "	
" 6	" "	44 "	
" 7	5 ounces.	47 "	5 "
" 8	5 "	39 "	5 "
" 9	3½ "	32 "	3½ "
" 10	2½ "	38 "	2½ "
" 11	3 "	37 "	3 "
" 12	3 "	27+ "	3 "

Measurements of urine here discontinued.

After August 1st the patient was catheterized once a day immediately after some one morning urination; during this time the greatest quantity of residual urine found was nine ounces, and the smallest quantity two ounces and a half.

Since being discharged from the hospital this patient has been under my observation. He has returned to his old occupation, and reports himself better than at any time during the past ten years, in that his urinary intervals are longer, and he has no vesical discomfort. I have always tested the amount of residual urine, and never found more than three ounces and a half, and generally two or two and a half. He uses a catheter once daily. There is no evidence of testicular atrophy or of any change in the epididymes, as remarked by physicians who have

examined him at society meetings where he has been shown. The only disturbance which may have been attributable to the operation was a sense of heat and itching in the feet and legs, especially at night. This possible reflex symptom is not so much complained of at present. The urethral distance is now eight inches and three quarters. The prostate is about the size of a duck's egg.

When this patient gave me the privilege to attempt anything for the relief of his retention I decided to test the efficacy of the trifling operation already described. If it failed, I had a chance of trying castration. When Dr. Mears suggested double ligation of the vasa deferentia as a substitute for Dr. White's operation, the latter promptly tested it on dogs, and was surprised to find that little if any difference in the marked loss of weight of the prostate was shown by the two procedures.

I have not seen recorded in this country any operation of this kind on man for the specific purpose indicated prior to my own; but I presume it has been done, and that this statement will be sufficient to elicit responses which will correct my oversight.

The functional result following (and presumably due to) the operation of double ligation has been so satisfactory in my single case that I feel I could not have asked for more had it followed castration. And when the relative risks of double ligation and prostatectomy, whether intra- or extra-vesical, are considered, I would not for a moment hesitate, in a similar case, to first give the patient the benefit of a chance of functional restoration by double ligation.

Having observed one fatal issue after castration where vigor and general health were apparently as good as in my subject, I came to view the procedure, in elderly people, as attended with a risk not easy to explain. Consequently a procedure which could omit systemic anæsthetization and the removal of any organs, even if they were but sentimental attachments, appealed to me. In future cases of prostatic hypertrophy causing retention I will continue to test the efficacy of double ligation; and if its results shall be found to compare favorably with those attributed to castration, the most striking advantage, apart from the increased safety, will be manifest in the patient retaining not only his anatomy but whatever virility these organs may be possessed of; for the artificial occlusion of the vas ought not to affect virility more than does an occluding funiculitis or epididymitis in connection with gonorrhœa.

Society Transactions.

THE NEW YORK DERMATOLOGICAL SOCIETY.

Two Hundred and Forty-sixth Regular Meeting, held on Tuesday Evening, October 22, 1895.

Dr. C. W. Cutler, *President, in the Chair.*

A Case for Diagnosis.*—Presented by Dr. John A. Fordyce.

The patient was a physician from Portland, Ore., who recently consulted him for an affection of the mucous membrane of the lips and oral cavity. The patient's attention was first attracted to the condition about two years ago by a symmetrical fading of the vermilion border of the upper lip, extending from the corners of the mouth almost to the median line, leaving only a narrow margin free next to the skin and a wedge-shaped area in the center of the lip. The two patches were connected at the inferior median line, where the lips come in contact, by a segment of a circle, making three patches, all of uniform color, with well-defined borders and areas slighly elevated. When first noticed the color was but a shade lighter than normal; the appearance otherwise did not seem abnormal, but, by putting the tissues on the stretch, small, irregular, closely aggregated miliumlike bodies just beneath the surface epithelium were plainly visible and completely covered with patches. While the borders appeared as well-defined lines, a chain of from one to three milium bodies could occasionally be seen in advance of the main patch, but not disconnected. The two sides have progressed symmetrically. On the lower lip was a parallel line of similar bodies extending horizontally through the center. The patient is unable to state positively whether there has been any extension of the condition since it was first noticed; he is positive, however, that the color has become lighter within the past six months. This he thought might be due to the fact that the bodies have become more closely aggregated. The subjective symptoms have been very slight. The patient experiences at times a slight immobility of the upper lip, which he is inclined to attribute to a dryness just above a nerveless tooth. This feeling preceded the onset of the above condition by several years. Within the past year he has felt a slight burning and itching of the upper lip, accompanied by some stiffness, as though the lip was swollen. This is only an occasional feeling, and may be due to errors of diet. The patient does not use tobacco or alcohol. His family as well as his past history is negative, and he is in good health at present.

Dr. Fordyce said that since the patient has been under his care he has curetted the lesions and made linear scarifications, and they are less distinct than formerly. He also cut out a piece of the affected mucous membrane and examined it microscopically; this examination has not yet been completed, but tends to show that the changes are entirely confined to the epithelial cells of the mucosa. There is a peculiar granular condition of the cells. The glands are not altered.

* A more extended report of this case will appear later in this Journal.

DR. GEORGE T. ELLIOT said he had several times observed a similar condition on the mucous surface of the prepuce. The lesions had the same appearances and presented the same symptoms.

DR. L. D. BULKLEY said he had observed a similar condition on the lips, and regarded it as akin to milium. He had never before seen the lesions on the inside of the mouth.

DR. R. W. TAYLOR inquired whether there was any involvement of the muciparous glands.

DR. FORDYCE replied that there was not. The changes seemed to be confined to the mucous surface of the mouth.

DR. TAYLOR referred to a case coming under his observation many years ago, in which there was considerable swelling of the lips with some thickening of the epithelium, and by passing the finger over the lip one could feel the small miliary bodies. The patient's chief source of complaint was that he could not open his mouth in the morning, as the lips would be glued together with a mucilaginous secretion. About twenty-five years ago Volkmann wrote an article on the subject, which he entitled Cheilitis Glandularis Apostematosa: he claimed that the pathology of the affection was a cell infiltration around the muciparous glands, and a secretion of mucus. In all these cases, the speaker said, there is probably connective-tissue inflammation of the structure of the lip, plus inflammation of the muciparous follicles. He did not agree with Dr. Elliot that any condition comparable to this is ever found on the prepuce. The condition may perhaps be simulated there by an infiltration or cell proliferation in the minute invaginations of the epithelium, but there are no follicles. Tyson's glands are very rarely found in the prepuce, and then generally in the child.

DR. GEORGE H. FOX said he did not think the term cheilitis was applicable to this case; there seems to be an obstructive condition of the glands not an inflammatory one. Dr. Fox said he had never before seen the buccal cavity invaded in these cases.

DR. P. A. MORROW said that the condition presented in this case is so extremely rare that the only way in which an intelligent idea can be gained regarding it is to study it under the microscope, as Dr. Fordyce is doing.

DR. S. LUSTGARTEN said that, from the superficial microscopic examination he had had the opportunity of making in this case, he was inclined to agree with the statement made by Dr. Fordyce. There seems to be an abnormal deposit of keratohyalin in the mucous membrane, which under normal circumstances is not found there. The speaker also referred to a somewhat similar (although not identical) condition described by Baelz and Unna.

DR. FORDYCE, in closing the discussion, said the histological examination in this case has been made too recently to show any positive results. The investigations have not yet been completed. The changes seem to be confined to the epithelial cells of the mucous membrane.

A Case of Epidermolysis Bullosa.—Presented by DR. ELLIOT.

The speaker said this was about the tenth case of this affection which had been seen. The patient was a young man who was sent to him last spring. The condition has been present since early childhood. It becomes aggravated in warm weather, better in cold, and he has sometimes escaped having any lesions whatever in winter. It is associated with excessive hyperidrosis,

particularly in the summer. In this case there does not appear to be heredity, none of his ancestors having the same tendency to the formation of bullæ. The speaker said he reported two cases last year, in one of which also no history of heredity was obtainable. This patient seems to be improving under treatment, but it is difficult to say whether the improvement is due to the treatment or to the onset of cold weather. This latter change is the rule in the disease.

Dr. Bulkley said that the patient had been in his service at the Skin and Cancer Hospital for a long time, and on several occasions he had observed bullæ develop on very slight provocation. They have developed on the hands and feet, making the patient practically helpless; also on forearms, back, and elsewhere. They could be brought out by the friction of the man's clothing. The treatment pursued during the past two months appears to have proved beneficial. Hot and cold applications by means of the spinal ice bag have been made to the spine morning and evening, and internally he had later the pernitrate of iron and phosphide of zinc. No bullæ have appeared for a month.

Dr. Elliot said these cases are of congenital origin—that is, begin very soon after birth, though one of his previous patients had developed the disease in adult life. In reporting his case last winter he made the statement that he regarded it as being due to "an acquired or hereditarily exaggerated irritability of the cutaneous vascular system" (Journ. of Cutan. and Gen.-Urin. Dis., January, 1895). A similar idea was brought out in the report of a case seen at Erb's clinic, published in the *Münchener Wochenschrift* of January 15, 1895, namely, that there is a congenital irritability of the blood-vessels which on the slightest provocation produces an immense effusion of serum and the formation of bullæ. It is very uncertain whether treatment in any way benefits these patients. In some of the cases reported the affection made its appearance a few weeks after birth, and it seems to persist indefinitely, though growing less marked with age. There is no case of spontaneous recovery on record. In some instances the hereditary tendency was traced through several generations.

Dr. Lustgarten said he did not think milder cases are so very rare. He has seen two where the lesions were confined to the soles of the feet and the palms. He is inclined to think that the condition bears some relation to dermographism, or factitious urticaria; that it is an extreme example of dermographism, with the formation of urticarial wheals and exudation as well.

Dr. Elliot said that one of the lesions in the case reported last year had been excised one hour after its formation, and showed inflammatory symptoms. Such symptoms are absent in urticarial lesions.

Dr. Lustgarten replied that such symptoms are also found in urticaria. We do not know where inflammation begins or ends.

A Case of Pityriasis Rubra.—Presented by Dr. Elliot.

The patient was a man who was first presented to the society three years ago as a case of erythrodermia, it being uncertain at that time what it would prove to be. Eighteen months later he was again presented with the diagnosis of pityriasis rubra. The symptoms of that disease are now very marked; the man's general health is failing, and he has probably only a few months to live.

A Case of Nævus Mollusciformis.—Presented by DR. FOX.

The patient was a young man with an extensive nævus mollusciformis or dermatolysis on the scalp. It was attributed to a maternal impression.

A Case of Mycosis Fungoides.—Presented by DR. MORROW.

The patient was first presented about a year ago as an example of the premycosic stage of mycosis fungoides, and it was interesting to note the changes that have taken place since then. The patient has had some glandular complications, some of the glands in the axillary region having suppurated. The erythematous patches have become more elevated, and upon the buttocks are seen numerous nodular prominences. Although none of the tumorlike formations characteristic of the mycosic stage have yet developed, the diagnosis would seem to be confirmed by the clinical features and course.

A Case of Erysipeloid of the Fingers.—Presented by DR. FORDYCE.

The patient was a colored boy who came under observation about a week ago, complaining of a redness and swelling affecting the fingers of both hands. Later on it extended to the palms. The boy's occupation was that of driver of a garbage cart.

DR. H. G. KLOTZ said he had no doubt that the condition of the fingers was due to a toxic infection, but he was not certain that it properly came under the title of erysipeloid. In the cases of the latter affection, which he had seen, the inflammation was not so diffused, but had a rather sharply defined border, which extended in a serpiginous manner.

DR. LUSTGARTEN said he considered it a typical case of Rosenbach's erysipeloid.

DR. ELLIOT made the same diagnosis.

DR. BULKLEY said he had never before seen a case of erysipeloid in which there were such multiple points of infection ; the case was interesting in that respect.

A Case for Diagnosis.—Presented by DR. JACKSON.

The patient was a baby, five weeks old, an inmate of the New York Infant Asylum. The mother died when the child was a few days old, and no history was obtainable. The child presented a peculiar thickening of the skin of the back and both axillæ. On the chest anteriorly the superficial veins were very prominent. It appeared to him like a case of scleroderma neonatorum, of which he had seen but one other instance.

DR. BULKLEY regarded the case as one of scleroderma neonatorum. He thought the condition would gradually grow worse and eventually cause death.

DR. FOX said if the case was one of scleroderma, it certainly differed from that which we meet with in adults. He had seen one or two somewhat similar cases of sclerema neonatorum, in which this condition of the skin was very marked and then disappeared in the course of a few weeks or months. He was not inclined to give an unfavorable prognosis in this case.

DR. FORDYCE thought the condition in this case was certainly allied to scleroderma neonatorum.

DR. LUSTGARTEN thought the case had the clinical features of scleroderma. It is possible that it might be due to a lymphostatic process, as there were symptoms of disturbed circulation in the distended veins in the upper part of the thorax. This interference with the lymphatic circulation might have induced first a chronic œdema and then a thickening of the skin.

Dr. Cutler said he presented a very similar case to the society some time ago, in which marked benefit was produced by massage and inunctions of green turtle oil. The diagnosis in that case was scleroderma, and the improvement was very marked indeed after the above treatment had been carried out for a few weeks. Several oils were tried in connection with massage, but no benefit resulted until the green turtle oil was employed at Dr. Janeway's suggestion.

A Case for Diagnosis.—Presented by Dr. Fox.

The patient was a girl, seven years of age. Three years ago an eruption appeared on the forehead and cheeks in the form of minute, warty elevations; the lesions on the cheeks have a red appearance, due to the vascular or telangiectasic condition on the surface of the elevated points. The lesions are rather pale in the morning and get redder during the day. On the back the child has a verrucous or fibroid growth, which has been there for five years; whether this originated in lesions similar to those now on the face it is impossible to say. The lesions give rise to no subjective symptoms whatever.

Dr. Morrow said it would be interesting to compare this case with one which he presented to the society in February, 1894 (228th meeting), and which he still has under observation. In that case the face lesions were almost identical with these, with the exception that there was a large patch upon the left cheek more like a nævus. From the peculiar features and mode of development of the eruption in his case, he assumed that it bore some relationship to that class of cases which have been described by Hutchinson as infective angioma. His patient also had a large cicatricial patch on the back, just below the shoulder and extending on both sides of the median line When the case was presented, the general impression among the members was that the lesion on the back was due to a sinapism which the mother had applied, and which might have resulted in the production of this scar tissue. The patch had a keloidal appearance, and in conjunction with it were numerous fibromata upon various parts of the body. The mother of the patient is a very intelligent woman, and she is quite positive that there were no lesions of an angiomatous character on the back preceding the development of the large patch. It appeared several months after the application of the mustard plaster.

Dr. Lustgarten regarded the case as one of multiple angiomata, whether lymph- or hæmato-angioma the microscope will show. He was inclined to believe that the lesions on the face and back were identical, only in a different stage of development, those on the back having brought about a formation of connective tissue.

Dr. Fox stated that the child's mother has never noticed any redness of the patch on the back, and a close examination of it by daylight will show that it is not cicatricial or keloidal in character. It is to be made up of numerous rather soft fibrous elevations, in linear arrangement, and so crowded together as to form a diffuse, elevated patch. On the forehead there are some lesions identical with those on the back, and even the red points on the cheeks seem to be formed of minute dilatation of vessels at the summit of the elevations.

Alopecia Areata following an Attack of Herpes Zoster.—Presented by Dr. Cutler.

The patient was a boy who three weeks ago had a well-marked attack of herpes zoster on the right side of the neck and scalp, the superficial nerves of the cervical plexus being affected. Two weeks later there was a rapid loss of hair, in patches, on the affected side.

DR. JACKSON considered the case a very interesting one. He was doubtful, however, whether the name alopecia arcata could properly be applied to it; it seemed to be rather inflammatory in its nature, as if it might be due to the local manifestation of the zoster.

DR. KLOTZ inquired whether the loss of hair was strictly confined to the sites of the herpes-zoster lesions, or extended over a larger area. In the former case it would be due to the local dermatitis, while in the latter it could be attributed to a nervous influence.

DR. BULKLEY said he had never seen herpes zoster of the scalp followed by baldness. It is a question whether the herpes can be regarded as the causative factor. He was inclined to agree with the diagnosis of alopecia areata due to nervous influence.

DR. CUTLER, in closing the discussion, said he saw the case every second day, and had a good opportunity to watch it. The amount of pain connected with the herpes zoster was very great—so much so that it required the use of an anodyne. He was able to state positively that where some of the herpes lesions had existed the hair had not fallen out at all, while it had fallen out in other regions where there were no herpetic lesions. He regarded the case as one of alopecia areata due to nervous influence.

Case of Chronic Eczema with Cretinism, favorably affected by Thyroid Extract.—Presented by DR. KLOTZ.

The patient was a boy, aged seventeen years, but looking not more than twelve, with similarly retarded mental development. Has had an affection of the skin since he was five years old, which on several occasions spread over the entire body and disappeared again. Dr. Klotz found the patient on taking charge of the service in the German Hospital, where he had been treated with little result for two months. The skin over almost the entire body was then of a deep-red color, thickened, on some portions œdematous, mostly covered with abundant small scales, except on parts of the legs and arms and the regions now affected—viz., the penis, scrotum, front and inner aspect of both thighs, and lower part of abdomen, which presented a dark-red, moist surface. These spots dried up under applications of boric acid and acetate of lead and of boro-vaseline; any attempt to use stronger remedies, as salicylic acid, resorcin, ichthyol, tar, etc, were followed by new acute outbreaks of vesicles, papules, and pustules like the present one. Dr. Klotz was not fully satisfied with the diagnosis of chronic eczema, and thought of dermatitis exfoliativa and of the eczematous condition of mycosis fungoides. Finally, in consideration of the general condition of the patient, which amounts to a mild degree of cretinism, he tried tablets of thyroid extract (Allen, Hamburg. London), beginning with one a day, gradually increasing to four, with excellent results on the general condition as well as on the skin affection. The appetite greatly improved, the skin became smooth, soft, and of a natural color, particularly in the face. The patient left the hospital in July almost cured, and was seen for some time in the dispensary, using nothing but boro-vaseline. Lately he has been working, but last week the present eruption appeared. On the scrotum and penis the skin is darkened, infiltrated, with a moist sur-

face and numerous cracks; on the thighs and abdomen many small elevated patches are seen, which on close inspection are made up from small vesicles papules, and some distinct pustules. The question arises whether the chronic skin disease is caused by the general condition of the patient, or whether it is to be held responsible for the impaired physical and mental development.

Dr. Jackson said the location and character of the eruption suggested impetigo herpetiformis.

Dr. Lustgarten said the boy showed undoubted symptoms of infantile myxœdema—i. e., cretinism. He was inclined to regard the eruption as an artificial dermatitis produced by some impure drug (for instance, vaseline), aided by a predisposition on the part of the patient to react to such influences.

Dr. Klotz said he knew of nothing that could have given rise to an artificial dermatitis, as only boro-vaseline had been employed. The boy had had similar eruptions on previous occasions.

Dr. Cutler said there was undoubtedly an eczematous element in the case.

A Case of Epithelioma.—Presented by Dr. Fox.

The patient was a woman, aged thirty-eight years, with a lesion on the face. The diagnosis, Dr. Fox said, lay between lupus and epithelioma.

Dr. Elliot regarded the case as one of superficial serpiginous epithelioma.

Dr. Klotz said that from the nodular appearance of the outline of the lesion he thought it was lupus.

Dr. Morrow pronounced the case one of lupus. He thought the minute nodules which have developed in the periphery of the scar were very characteristic of that disease.

Dr. Lustgarten pronounced the case one of superficial epithelioma.

Dr. Cutler regarded the case as one of lupus.

Dr. Fox said he based his diagnosis of superficial epithelioma upon the semicircular margin of the lesion, the tendency to a scalloped border, its serpiginous character, and the whitish waxy line that can be made out. The case illustrates the fact that lupus and superficial epithelioma, especially after it has existed for some time, may closely resemble one another.

Dr. Morrow inquired whether the duration of the disease would lead Dr. Fox to modify that diagnosis. In this case it had existed for nine years.

Dr. Fox replied that superficial epithelioma may remain for that length of time, and then within a few months it may take on decided action and rapidly spread, especially when located near the eyelids.

Dr. Elliot referred to a case of superficial epithelioma which had existed for seventeen years before it began to spread rapidly.

Dr. Fordyce said, in the case shown by Dr. Fox, he was under the impression that there were some lupus nodules in the scar tissue.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY. STATED MEETING, NOVEMBER 12, 1895.

ALEXANDER W. STEIN, M. D., *Chairman.*

Case of Urethral Chancroid.—DR. GEORGE SWINBURNE reported such a case. The man had visited him in July of the present year, having a urethral discharge of four days' duration, eleven days' incubation. Numerous micrococci were found, but no gonococci. Several days afterward, when irrigating the urethra, he noticed that the man flinched when the glass nozzle was placed in the meatus, and on examination a chancroid was found at the fossa navicularis. He made further examination of the discharge, and found, besides numerous micrococci, the bacillus described by Krefting, and which is known as the Ducrey-Krefting bacillus. He sterilized a spot on the man's abdomen and inoculated it with the discharge from the meatus, covering the spot with a watch-glass held by adhesive plaster. At the end of forty-eight hours there was a round pustule, and from this he made cultures at intervals of forty-eight hours. The third culture showed only micrococci. Therefore, as a test for obtaining a pure culture of the Krefting bacillus, it was a failure.

The chancroid healed under applications of nitrate of silver and nitric acid.

Case of Chylous Hydrocele.—DR. F. TILDEN BROWN presented a young man, a native of Syria, who had been in various countries. A year ago he noticed a swelling on the left side of the scrotum. No history of injury, nor of venereal disease. In May, 1895, the hydrocele was tapped by Dr. Brown's assistant at the clinic, and three or four ounces of milky fluid were withdrawn. The patient did not return until July, when he had enlargement of the scrotum on the left side, of the size of an orange. Four ounces of a milky fluid slightly tinted with blood were withdrawn. The lobus minor and major of the epididymis were both distinctly enlarged and hard. After withdrawing the fluid, a solution of carbolic acid, one to twenty was thrown into the sac, worked about, and then what would was allowed to escape through the small cannula. The patient was kept in bed a week. On August 15th the tumor was reduced to the size of a hen's egg ; no pain. In all cases of hydrocele treated in this manner there was subsequently temporary enlargement. It was so in this case, a little time being taken for the enlargement to subside. At this time the globus minor was cup-shaped and spread out over the lower margin of the testicle, but to-day was normal, and there was only slight enlargement of the globus major. The urine had contained no blood, no chylous elements. The hydrocele fluid was found to be turbid, milky, and to contain a considerable number of red cells ; no leucocytes, and a great number of fat granules ; no tubercle bacilli ; no filaria ; no growth on agar.

Case of Ligation of the Vas Deferens for Prostatic Hypertrophy.*

Treatment of the Pelvic Complications of Gonorrhœa in Women.—DR. W. R. PRYOR read this paper. He said that some gynæcologists always removed the uterus as well as the adnexa where the latter were destroyed by disease, for such radical treatment was followed by a smoother recovery and less

* See page 21.

mortality. But removal of the uterus was followed by cessation of the menstrual flow, and in young women by certain mental disturbances, and for this reason we were compelled to resort to less radical operative work.

He divided the cases into those of acute salpingitis, those of chronic salpingitis with acute exacerbations, and those of hydrosalpinx and pyosalpinx. Of the former, he had operated upon seventeen cases, and he laid stress upon the fact that the attack was the first, and was acute, although in three in which he subsequently had to remove the uterus the attack had lasted about three weeks. In all seventeen there were enlargement of one or both tubes, acute pain, tenderness, often tympanites and vomiting. In these cases the tubal enlargement was almost wholly in the wall, the lumen not being distended. Dr. Pryor stated here that he looked upon the lining membrane of the uterus as a lymphoid structure, not a mucous membrane. As stated, the lumen of the tubes was not distended, and he believed firmly in their reparative power if curettage were done early after the acute attack. All of the seventeen cases recovered except the three referred to. Subsequent to treatment there was no enlargement, no pain. All the women menstruated normally.

There were certain cases which had gone longer, but had acute symptoms, and in them the best results followed curettage of the uterus, supplemented by posterior incision in Douglas's *cul-de-sac* and packing the pelvis with gauze. The procedure contemplated isolation of the infected area, as well as curettage of the original seat of infection, the endometrium. He had applied this treatment in seven cases successfully.

Cases of recurrent chronic salpingitis were very common. The tubes contained not only pus, but the walls were dense and hard, and were the site of fibrosis. For these women we could do least. While curettage of the uterus had little effect on the tubal trouble, it was carried out as treatment for the first site of infection. He had learned within a year to open the *cul-de-sac* in these cases, break up the adhesions, and drain by gauze at the lowest part of the *cul-de-sac*. Temporary benefit always followed, with much relief of local symptoms, but the reparative powers of these tissues was always much damaged. In hydrosalpinx and pyosalpinx it was important that the adhesions to omentum, etc., be not disturbed. The posterior *cul-de-sac* should be opened and the tube drained. Then introduce the finger, tear open the tube, and literally pack its cavity with gauze, using two to four yards. If reinfection could be prevented there would be no return.

Dr. Pryor repeated that some women objected to removal of the uterus, and having to heed their wish, he regarded less radical operative treatment as described much better than the old let-alone policy.

Electrolyzer for the Surgical Treatment of Stricture.—By Dr. J. A. Fort, of Paris.

It was a well-known fact that urethral electrolysis had been largely discarded on account of imperfect instruments. The instrument which he had devised looked like a urethrotome, but in use had not the inconveniences of the latter. It looked like a small whip, tapering almost to a point, quite flexible, with a bow of platinum near the middle, and a flattened projecting edge to act as the electrolytic point as it gradually passed through the stricture. The instrument having been introduced into the urethra, it was connected with the negative pole, the positive electrode being placed on the

thigh or over the pubes. The instrument, the small flexible distal end of which had already passed the stricture, was pushed down until the platinum arch encountered the stricture, when the current was turned on, about ten milliampères, sometimes twenty, in cases of hard stricture, and usually in a remarkably short time, thirty seconds, it went on through the stricture. In almost all cases there was no bleeding, or very little. The urethra was made aseptic before and after the operation. The operation was almost painless; the electrolyzer remained perfectly cold during the passage of the current. Usually the wound healed quickly, without any local treatment, and often the patient could go about his business immediately. In most instances he passed the sound the third day after the operation, and usually also the day after that. The patient was instructed to continue the use of the sound for a month or more.

Dr. Fort had been able to demonstrate two classes of strictures, soft and hard. Hard stricture was present in the proportion of one to five for soft stricture. The time required varied with the density of the stricture, but averaged thirty seconds. Sometimes cases were encountered in which the stricture was too hard to be operated upon successfully by this method.

Up to date Dr. Fort had performed in Europe one hundred and thirty-five operations for stricture of the œsophagus, and, with the exception of those caused by malignant growth in the walls of the œsophagus, all had recovered. He said it had been his good fortune to meet in New York the leading authorities in the treatment of strictures, and he was very grateful to them for their kindness in giving him the opportunity to demonstrate his method on some of their patients.

The several cases were related in detail, most of them having been in Bellevue Hospital in the service of Dr. R. W. Taylor, some in the service of Dr. Gouley. The first case, a sailor, sixty years of age, was admitted to Bellevue on October 12th. Five strictures of twenty-five years' duration, the deepest being located seven inches from the meatus. The urethra had ruptured, and there were urinary infiltration and abscess. The patient urinated with great difficulty every two hours, the urine being fœtid. A No. 3 French filiform sound would hardly pass. The man was operated upon by Dr. Fort by linear electrolysis, the instrument passing through readily, and the patient was afterward able to urinate in a large stream, and in a few days the fluid became normal. Within a few days the sounds which were passed had been increased up to No. 24 French. Later a surgeon operated on the abscess which had been present, and the patient was discharged completely cured.

Third case, in Dr. Taylor's ward. The patient had had two attacks of gonorrhœa; stricture for four years; two years ago had been operated upon by internal urethrotomy at one hospital, and later by external urethrotomy at another hospital. There were five strictures. He urinated every two hours, the flow being turbid. Electrolysis October 30th. The first four strictures were soft, being passed in a few seconds; the fifth one was hard and required three minutes. There was no bleeding. The first passage of sounds afterward was accompanied by chills, but by November 4th no more chills occurred, and No. 10 French was passed on the 5th. Electrolysis again; no accident; passed No. 17 French after the operation.

Another patient in Dr. Gouley's clinic; stricture in membranous portion; fifteen or twenty minutes required to introduce the filiform leader, twenty-

five seconds to pass the electrolyzer ; urine afterward flowed in a good stream, and Dr. Goulcy passed a No. 17 French sound. In another case the stricture was unusually hard and ten minutes were required for the cold electrolyzer to pass it, and there was a little bleeding, but later No. 18 French passed.

The discussion on Dr. Fort's paper was then opened by Dr. R. W. Taylor, who said that Dr. Fort had been introduced to him by a mutual friend, and he had placed six cases of urethral stricture at his disposal at Bellevue Hospital. Dr. Taylor thought it was not necessary to go over the ground of the failure of electrolysis in the treatment of urethral stricture as it had been used for a number of years in this country. The method employed by Dr. Fort was quite different and far more successful. He was unwilling, however, to pass final judgment upon the results until they should have been observed a longer period of time, say six months. Dr. Taylor then went over the several cases reported in the paper and occurring in his ward in detail. The electrolyzer passed through the soft strictures in a remarkably short period of time, and through the hard strictures easily also, but after a longer period. This, of course, was only the introductory step, for dilatation had to be carried on afterward with sounds. He remarked especially upon the first case, that with urinary infiltration, and said that it was one in which he certainly would have done external urethrotomy had Dr. Fort not requested a trial with the electrolyzer. He must say from what he had seen of the method, that it was worthy of extended trial.

Dr. William James Morton said he had had no experience with the treatment of strictures by electrolysis, but speaking from a general knowledge of the action of electricity he could appreciate the value of the method. He thought the practical point was that it was a form of internal urethrotomy, and he could see very little difference between cutting and electrolytic decomposition of the platinum point and the cutting of the knife, but he supposed experience would show what the difference was practically between the two methods. It was said that electrolytic action was antiseptic, but then an open wound was left, and he supposed this would afterward be subject to septic influences as any other incision. He thought that if an instrument the size of the one presented passed through strictures within half a minute, it showed that the tissues must be very loose, possessed of little density ; but he noticed that ten minutes were consumed on a hard stricture. That was a long time. He would suggest that with other metals than platinum the stricture, if a hard one, could be cut by the electrolyzer in a shorter time.

Dr. Samuel Alexander said that by request of Dr. Taylor he had witnessed the operation on two cases, and while one could be excluded from consideration, he was not convinced in the other but what the method amounted practically to dilatation and divulsion.

Dr. Taylor remarked that it was rather more than dilatation, for detritus was withdrawn as the result of the electrolytic action.

Dr. C. W. Allen did not see why divulsion should be invoked to explain the cases, for in using an electric needle on the skin it showed detritus as the result of electrolytic action.

Dr. Morton added that he did not doubt but what the action was by electrolytic cut, not by pressure. Some who were not acquainted with the action of the electrolytic needle supposed it must get hot, but this was not true.

Dr. Guiteras had seen four of the operations, and regarded the elec-

trolyzer as exceedingly valuable in small strictures. Almost no force was required. The size was increased to the point where dilators could be used.

DR. F. TILDEN BROWN had made some studies of electrolysis in urethral stricture as practiced in America, and had made an unfavorable report. The term electrolytic action had been used. This had seemed to him vague. But here we had what was called the electrolytic cut, which was a clear term, meaning that the tissues were really severed. He thought experiments should be made on the cadaver, to determine exactly the action. The beneficial results from the older method of electrolysis in urethral stricture, when any took place, had seemed to him to be due in part to the anæsthetic influence on the contractures, and in part to what might be spoken of as saponification of mucoid material, resulting in passing instruments more easily and relief of retention.

Case of Dislocation of the Testicle.— By DR. RAMON GUITERAS.

The patient had been run over by a cart, the wheel passing up between the thighs and over the left pubis and scrotum, left side of the abdomen, and off his body, after fracturing two ribs in the axillary line. An ambulance was sent for and he was taken to a hospital, where his ribs were attended to and he was put to bed. Shortly afterward they noticed discoloration over the left side of the thigh and scrotum, and applied an ice-bag. The patient remained in the hospital about three weeks, and when he went out observed that his scrotum did not look normal. He was referred to Dr. Guiteras, who found dislocation of the testicle, the organ having been torn from the epididymis, forced through the parietal layer of the tunica vaginalis, and up alongside the penis, between the glans and base. As he could not reduce it, he made two incisions, one over the testicle at the side of the penis, another in the scrotum over the globus major of the epididymis, and replaced the organ. The case had done well.

Case of Pyonephrosis due to Nephrolithiasis.—DR. GUITERAS reported this case. The woman had previously been well. A year and a half ago she began to have pain and distress in the right umbilical region, and six months later noticed a small tumor here which went on to increase in size. There was variation in the morning and evening temperature. The urine contained some albumin, some pus, but at times was clear. The diagnosis of pyonephrosis was made, with interrupted flow of pus. The other kidney was regarded as healthy, for the urine was clear at times. The diseased kidney was removed. It measured $8 \times 5{\cdot}5 \times 4{\cdot}5$ inches, contained a pint of pus and a number of phosphatic calculi. It was saeculated. Its walls collapsed on evacuating the pus. The patient died of acute suppression of urine, and post-mortem showed the other kidney acutely inflamed. Diuretics had been given —sweet spirits of niter, digitalis, strychnine—and the question arose whether it would not have been better to have avoided these, and to have done nephrotomy instead of nephrectomy, and drained, as the operation would have been shorter. With attention to the skin and bowels, the remaining kidney might have done its work better without diuretics.

The kidney contained four unusually large calculi, one measuring $6{\cdot}5 \times 3{\cdot}5 \times 1{\cdot}5$ centimetres in diameter, and all had facets.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

Treatment of Hypertrophic Acne at its Beginning.—The methods of proeedure most used in France up to the present time in the treatment of rosaeea and of eommencing hypertrophie acne are linear cross-scarifications and cauterization done with fine points either of the thermo-eautery or electrocautery. Scarification is effieacious only against telangieetases, little or not at all so against tissue hypertrophy. Cauterization by heat, on the eontrary, is exeellent for the reduction of volume of the hyperplastie parts, but it leaves rounded, more or less deep depressions corresponding to the eauterizations and separated from each other by little elevations in spite of the eare taken, so that quite often, especially in subjects whose lesions were already accentuated, an appearance may result from this method similar to that produced by variola.

In faee of these unsatisfaetory results, it oeeurred to us in 1888 to use electrolysis in beginning hypertrophie acne. We have been led to experiment with the method in this affection by the idea that we would perhaps be able to modify the oily seborrhœa whieh so often eomplieates rosacea by introdueing the eleetrolytic needle into the glandular orifiees whieh dot the integument of the nose, and eausing the eurrent to act on the glands themselves.

Aeeordingly, we attack the dilated openings of the sebaceous structures ; we introduee the eleetrolytic needle attaehed to the negative pole into their interior to a depth varying with the thickness of the skin, so as to act upon almost their entire depth ; and we use eurrents, aecording to the resistance or pain in different individuals, whose intensity varies from one and a half to five milliampères. When the orifiees are greatly dilated, we make circumduetory movements of the needle, which permits the current to act upon all the walls of the duct, and whieh at the same time facilitates the egress of the fatty matter aeeumulated there. When we consider the destruction of the gland sufficient, we eut off the current and withdraw the needle. This result is reaehed when there form vesieles of one and a half to two millimetres in diameter, corresponding for skins of a mean resistanee to the passage of a eurrent of two milliampères of intensity for twenty seeonds. Another orifice is ehosen, distant at least five millimetres from the preceding, in order that the vesicles of destruction may not beeome extensive, leaving ugly eieatrices.

When a sufficient number of points have been operated on (unhappily, they are limited, for rarely can more than two or three a minute be made, except in courageous persons who are able to endure eurrents relatively quite strong) all of them are earefully eovered with anhydrous fat saturated with spirits of camphor, then lightly dusted with starch powder—or, better, an ointment eontaining borie acid (1 gramme), zine oxide (4 grammes), vaseline (15 grammes), and a powder dusted over as before. We reeommend to the patients to make at least three times a day applications of spirits of eamphor. We have observed that by taking this simple preeaution the skin lesions caused by the negative eleetrolytic needle heal with the greatest rapidity and the least complication.

One of the advantages of this method is the possibility of beginning an-

other sitting on the next day but one, often even on the morrow—at the latest, in cases where the diseased surface is already pitted, on the fourth or fifth day. When it appears that visible sebaceous glands have been sufficiently acted upon (it is often necessary to return several times to the same orifice), if the oily seborrhœa is intense, if the skin hypertrophy is accentuated, we attempt to find in the interval orifices of sebaceous glands of a medium diameter and depth, and we use the needle upon them. Finally, we end when there is necessity, as in vascular dilatation, by destroying them with needles directed parallel to the surface of the skin. Summing up, by this electrolytic method applied to hypertrophic acne in its beginning, one may in certain measure act only on the four following elements : (1) on dilated and hypertrophied sebaceous glands ; (2) on the oily seborrhœa, logically the result of the first ; (3) on tissue hypertrophies ; (4) on vascular dilatations.

It seems, moreover, that—employed with method and precaution, as we have just said—it leaves only few or no visible cicatrices, that it determines a kind of retraction *en masse* and quite uniform of the tissues, together with a general whitening of the regions operated on. We believe, then, this procedure far more efficacious than scarification and far more æsthetic than the results of fiery cauterization. Still, there is a disadvantage, in our opinion, in the multiplicity and length of the operative sittings. We have also attempted to render it more rapid by combining it with other known methods.

a. When the patient is a woman, if the integument is only slightly thickened, it is necessary to make a trial of scarification alone, with lotions and applications of sublimate and chlorhydrate of ammonium. If the skin is infiltrated, electrolysis, according to the operative multiple method we have indicated, must be used so as to act upon the cutaneous hypertrophy, on the seborrhœa, on the varicosities ; if necessary, finish with scarification, in order to have a skin as white, supple, and uniform as possible.

b. When a man is the sufferer, if the hypertrophy of the skin is only slightly marked, scarification is to be employed ; if the hypertrophy is marked but does not disfigure, the same line is pursued as in women ; finally, if the hypertrophy begins to be a real deformity, vigorous intervention is called for in the shape of deep cauterization done with the finest points of the electrocautery that are at hand, in such a way as to obtain a rapid reduction of volume. Continuing, if necessary, with sittings in which electrolysis is the agent, the various traces left by the scarifications will be made to disappear. The latter have, moreover, the advantage of destroying the varicosities which would have escaped other methods.

Striæ and Gray Points in Lichen Ruber Planus.—DR. L. WICKHAM has just drawn attention to a peculiarity of lichen ruber planus which has been until now overlooked by a majority of authors, but which is found mentioned however, in Ziemssen, in Hardy, and, if we may be permitted to say it, in our work on the treatment of skin disease. According to Wickham, when the larger isolated papules in typical lichen ruber are examined with care, it is seen that the flat and glistening surface of the papule is composed of two differently colored portions—one rose-tinted, the other grayish. The pink portion forms the coloring of the deeper part of the surface, on which are imposed the gray striæ ; sometimes one, sometimes the other of the two predominates in extent. The grayish part shows besides the most varied aspects : sometimes it is central, rounded in the shape of a wafer, surrounded by a rose-colored zone ; again it is disposed in striæ which traverse in every

direction the surface of the papulæ, and form either a star or a principal band from which are detached lateral projections ; at other times it takes the form of a single stria or isolated points. Dr. Wickham believes that this characteristic is pathognomonic of lichen planus ; it is not found in any similar dermatosis. Hence, when it exists in an eruption, it confirms the diagnosis of the lichen planus of Wilson.

Two Cases of Psoriasis treated by Mercurial Injections.—We continue, as they are published, to call attention to the new methods of treatment of psoriasis which constantly appear, a more and more evident proof of the *quasi*-incurability of the disease. Now it is Dr. J. Brault who, without too much enthusiasm, we must say for him, has just recorded two cases of cure of this affection by subcutaneous injections of insoluble mercurials. He has chosen for his experiments two cases of psoriasis, pure and typical, one young, the other advanced in years, both free from any syphilitic antecedents, either acquired or hereditary, and he has submitted them both to injections of yellow oxide of mercury to the exclusion of all other medication, internal or external.

The first case was a student of twenty-two years, suffering from psoriasis from the age of fourteen, relieved of several attacks of the affection by various procedures—oil of cade, chrysophanic acid, arsenic, etc.—and attacked by a general outbreak. On March 16th, the first injection of five centigrammes of yellow oxide of mercury was made; four were made from then to April 16th; from May 9th to June 17th three others were given him of ten centigrammes each, so that in the space of about three months he received seven injections, four of five centigrammes and three of ten centigrammes. After the sixth, on May 23d, all trace of the psoriasic eruption disappeared. The second observation is absolutely identical. We repeat that we merely offer these facts without any conclusion.

Case of Colles' Law in a Professional Nurse.—Dr. H. Feulard has recently presented to the French Society of Dermatology a most interesting observation of a professional nurse of whom a word should be said in view of practical questions of the greatest importance which place themselves before us.

This woman came to the Children's Hospital with her child unmistakably attacked by syphilis, not acquired, but hereditary. The mother presented no trace of syphilitic infection; a minute inspection seemed to demonstrate that she had never had it. Her accouchement took place without difficulty; the child at its birth was normal; nineteen days afterward she came to Paris with her baby, and went to the prefecture of police to have herself visited and inscribed as a nurse. She installed herself in an employment bureau and remained there a month. She found entrance finally into a family as a nurse. She remained twenty-one days in her place, then left it because the child, attacked by digestive troubles, was put on sterilized milk. She returned to her parents, and arriving there, found her own child ill. She returned with him to Paris, went to a bureau and again visited the prefecture, whither she went without her child. The latter becoming more indisposed, and having spots on its thighs, she took it to the consultation of the Hôtel-Dieu, where it was thought to have a fever erythema. Finally, she went to the Children's Hospital, where Dr. Feulard examined the baby, and recognized a typical eruption of syphilis, a diagnosis confirmed some hours later by Prof. Fournier, in the service to which she was admitted.

This is one of the most beautiful examples conceivable of the law of Colles—that is to say, of a mother presenting and having presented no ap-

parent symptoms of syphilis, yet giving birth to a child heredito-syphilitic and nursing it without contracting a mammary chancre. It demonstrates, moreover, what circumspection is necessary in giving certificates of health to nurses. In order to be able to do so with certainty, it would be necessary to give it only to those delivered more than three months previously, and after minute inspection, not only of the woman, but of the child, on several occasions during these three months. Dr. Feulard asks himself further if we can permit such a nurse to enter a healthy family. The answer is No, although the chances are that the syphilis will remain latent, and although the milk is incapable of transmitting it. As he has remarked with reason, there is no absolute certainty, and a syphilis of conception, however benign and attenuated it may be, may at any moment become changed by an exterior accident. On the other hand, it should be remarked that she would be an ideal nurse for a syphilitic infant.

Finally, he puts a last question, and asks if she should be treated, and how? We regret that Dr. Feulard has not thought it necessary to give his opinion on this point. The solution of this problem seems to us to involve the whole discussion of the treatment of syphilis. Should syphilitics be treated in a preventive manner? Should they be treated only when they have perceptible syphilitic accidents? According to the school to which he belongs, one will and another will not treat patients in the situation of the nurse whose case we have related. As for ourselves, we do not hesitate: these women are certainly syphilitic, since they are refractory to inoculation; they are syphilitic to a slight degree, since they present no exterior manifestation of infection; they seem, then, to require moderate antisyphilitic treatment. By not taking sufficient care of them, we lay ourselves open later to severe censure if by chance they are attacked by grave tertiary accidents.

Rapid Efficacy of Subcutaneous Injections of Calomel in Tertiary Laryngitis.—Dr. Mendel has previously made known the case of a young woman attacked by tertiary syphilitic laryngitis in whom he secured a very rapid amelioration by means of a five-centigramme subcutaneous injection of calomel. This patient has since been again attacked by an intense dyspnœa caused by sudden infiltration of the vocal cord. Dr. Mendel immediately gave another injection of calomel, and in the space of twenty-four hours the dyspnœic accidents had disappeared.

The same author publishes a second analogous case. This time the patient was a young man of twenty-nine, syphilitic since 1889, who since 1892 had laryngeal accidents. Examination with the mirror revealed swelling and diffuse redness of the whole mucous membrane, and a considerable infiltration of the left false cord, which lay in contact with the right vocal cord and narrowed the glottis more than half. The patient had besides a sclero-gummatous glossitis and a diffuse syphiloma of the lower lip. Twenty-four hours after the first injection of five centigrammes of calomel, respiration was re-established in a satisfactory manner, and the laryngoscope showed that the infiltration of the right ventricular fold had diminished one half. Afterward, the injections were continued, with positive success, but, however, without the amelioration being carried on with the same rapidity. There is, on the contrary, a certain tendency of the lesions to resist medication. In spite of this, the truly remarkable results—e. g., the rapidity—which injections of calomel give in tertiary syphilis of the larynx can not be denied. L. BROCQ.

Paris, October, 1895.

JOURNAL OF
CUTANEOUS AND GENITO-URINARY
DISEASES.

VOL. XIV. FEBRUARY, 1896. No. 2.

Original Communications.

HYDROA ÆSTIVALE.*

BY JAMES E. GRAHAM, M. D.,
Toronto, Canada.

THE following two cases of this somewhat rare affection are contributed simply with the object of adding to the small number already published.

Case I.—A. B., child, aged six, came under my observation in the early part of the summer of 1880, fifteen years ago, when the following notes were taken :

The patient, a native of Quebec, had always lived in Canada, and for the last four years and a half had resided in Chatham, in the western part of Ontario, a district in which at that time malaria prevailed.

There is nothing of note in the family history more than that the children do not seem to have been robust. Four out of seven died in early life from various diseases. The mother had one miscarriage three years before the birth of this child. There is no history of syphilis. Two years ago, in April, 1878, some small red spots appeared on the face, and a few on the hands. About a week after their appearance the patient was attacked by diphtheria, and while confined to the house the spots faded away without leaving any scars. Similar spots appeared in June, after she commenced to go outside. They grew larger, became vesicular and then pustular, attaining their full size in two or three days, when a dark spot appeared in the center of each, after which a scab formed over the whole surface. These dried up

* Read before the nineteenth annual meeting of the American Dermatological Association, Montreal, September, 1895.

and fell off in a few days. The whole duration of each crop of vesicles was about nine or ten days. During the summer successive crops of this eruption appeared, which in many instances left permanent cicatrices.

In every instance the attack followed exposure either to the direct or reflected rays of the sun. In the autumn of 1878 the eruption disappeared altogether; but in the latter part of the winter of 1878–'79, after driving on a bright day, when the snow was on the ground, her face was again affected. In the spring of 1879 spots appeared first on the face, on the part not protected by her winter hood. When she ceased wearing the hood more of the face became affected. While wearing gloves the hands were not affected, but became so when she left them off. The wrists, which were covered for a time after she ceased wearing gloves, were attacked when she left off her cloak, which by its long sleeves had afforded protection. She experienced a slight burning sensation when the rash appeared, but it was not itchy at any time. She had scarlatina in the winter of 1879–'80. This had no special effect on the eruption, except that it faded away during confinement to the house, as it always does when she is not exposed to the sun's rays. She has constantly worn a glove on her left hand since May 1st, or four weeks, and no fresh spots have appeared on the hand during that time. The eruption is less marked in the winter, partly because she is kept more in the house, and partly, her mother thinks, because the rays of the sun in winter do not seem to have quite the same effect as in summer. It always appears if she goes out, if the sun is shining, and sometimes after sitting at an open window if a warm wind is blowing, although the sun's rays do not shine directly on her. No effect is produced on a dark, cloudy day.

Patient had an attack of ague some weeks ago, and has now some symptoms of that disease. Her appetite is fairly good. She is fond of acids, especially vinegar.

Present Condition.—A copious eruption is present on the face, ears, and right hand. On the face it consists for the most part of lesions, ordinarily about the size of a ten-cent piece, a few even larger. Some are umbilicated, and resemble smallpox pustules; others are covered with scabs, while very superficial cicatrices are found in situations where scabs had previously existed. The nose is swollen, and presents the same appearance as the face. The lips are much swollen, and covered with large pustules, which are elongated, extending along the margin. There is more or less general swelling of the face. The patient was vaccinated when eight years old, and the vesicles were a long time healing.

Nearly every form of application seemed to aggravate the disease. During the past winter, even when she remained constantly in the house, small spots appeared occasionally. These, however, did not become vesicular, and soon faded away.

In August of 1879 she was taken to Snowden, in the woods, where she lived in a log house. Her general health was better, but the eruption remained unchanged. The patient was seen several times in the summer of 1880, and various applications were used without any good results. She then passed from my observation, and nothing more was heard of her until this summer. I learned from her friends that her condition remained the same until the thirteenth year, when menstruation commenced. From that time until the eighteenth year the eruption gradually disappeared, and at the latter age it ceased entirely. During that time a thin gauze veil seemed quite sufficient to protect the face from the rays of the sun. Since the eighteenth year her health has been remarkably good in every way.

Case II.—C. D., female, aged twenty-five, a blonde. Notes taken in August, 1895. When ten years of age the patient had a chronic swelling of the left knee joint, probably of tubercular character. The limb was on this account amputated. Although not strong, her health has been good since the operation. The parents remember that previous to the amputation an eruption appeared on the face and hands. The patient, however, dates the commencement of her trouble at a period fourteen years ago, when she was eleven years of age, and it has steadily continued since that time until this summer. For the last two months it has been much better, and at the present time her face is quite free from eruption. The phenomena during the fourteen years have changed very little, and were described as follows: When she was exposed to the sun's rays for about twenty minutes or half an hour she noticed a burning sensation on the unprotected parts of the body. This would soon be followed by extreme swelling and the formation of small water blisters. These in two or three days would become yellow, and scales would form on the surface. These were not thick, and would speedily dry up and fall off, leaving a congested surface which would soon return to the normal condition. The pustules, so far as I could learn, were never umbilicated. The crops of pustules varied in duration according to the severity of the attack. The process in some attacks did not last longer than eight or ten days, whereas at other times it lasted two or three weeks. The swelling was greater on some occasions than others, sometimes almost closing the eyes and producing a good deal of deformity of the features. The attacks were accompanied by general *malaise*, coryza, sleeplessness, and anorexia.

The eruption will occur on any part of the body exposed to the sun. On one occasion she had a very light covering on the legs and thighs, and an eruption appeared on these parts after a short exposure. It occurs in the winter just as in the summer if the sun is shining. If she sits near a window the eruption will appear even if the sun is not shining directly on her. She is of the opinion that a very cold wind in winter would have the same effect, but she is not certain, and she could not give any instance in which the eruption had come out after such exposure. A sufficiently thick veil always prevents the action of the sun. She is afraid to go out even on a cloudy day, and has been kept almost a prisoner in the house for the last fourteen years, at least during the summer, only going out in the evening after the sun had gone down.

Dr. Phillips, who has had charge of the case for the last three or four months, kindly gave me the following description of the eruption from notes he took at the time:

When he first saw the patient, in April last, the hands presented a thick, hard, dry, and fissured skin, with a few vesicles. The face and ears were covered by thick scabs beneath which existed a sero-purulent discharge. The presence of vesicles and some infiltration gave the parts the appearance of a chronic eczema. The thickened skin was removed by resorcin ointment and by Unna's plaster of salicylic acid and creosote. In two weeks the parts had resumed their normal condition. Dr. Phillips, who had recently spent some time in London and had seen Hutchinson's case, at once made the diagnosis of hydroa of Bazin.

In the month of May a relapse occurred. When seen by the doctor the day after exposure, the backs of the hands, fingers, and wrists, and one side of the face, presented an erythematous, swollen appearance. The surface of the wrist was closely packed with vesicles about the size of a grain of wheat, filled with a sero-purulent fluid. A week later the vesicles had disappeared, leaving scabs and crusts situated on a thickened and reddened integument. The skin afterward was fissured and scaly. Under the same treatment as before described all evidence of the eruption passed away. As previously stated, when I saw her in August the skin was quite normal, except that there seemed to be an absence of pigment over small patches, and the eyebrows have to a great extent disappeared.

It is quite evident from the description of these cases, as well as from those given by Unna, that the eruption is not always of a vacciniform character, and that therefore the term hydroa vacciniforme does not apply to all cases. In the first one, just described, the vacciniform

appearance was quite striking; whereas in the second, a case in all respects similar, the eruption was of a vesicular and bullous character. The term hydroa puerorum, adopted by Unna, is also inappropriate, as my first, a case of typical hydroa vaccineforme, occurred in a girl. In the great majority the patients have been boys, but some cases of females have been recorded. Berliner describes a case in a female, twenty-three years of age, who had suffered from the disease for nineteen years. The case described by Veiel under the heading of eczema solare, a female fifty-six years of age, and the one given by Unna, were, so far at least as the ætiology is concerned, identical with those described by me. Boeck gives the case of a female, twenty-seven years of age, in whom the eruption had existed two years. Von Dort's and Burri's cases were also females. It would appear that, as a rule, the condition is found in females later in life than in males. It is also more eczematous in nature and less likely to leave scars. The persistent character which the affection sometimes possesses is illustrated by the second case, as also by those recorded by Veiel and Unna. I have adopted the term hydroa æstivale. The direct rays of the sun are not the only cause, as it may arise from the heated atmosphere of a room when the sun is shining. My second patient knew by experience exactly how near she could sit to an open window with safety, and then there was much greater danger when the window was open than when it was closed. There was no evidence in either case that cold winds in winter would produce the eruption, although the patient was under the impression that they might. The heat from a stove had no effect in either case.

Berliner includes the cases which we are now discussing, with those of the summer prurigo of Hutchinson, under the head eruptio æstivale, and makes two divisions: eruptio æstivalis pruriginosa and eruptio æstivalis bullosa. The two classes of cases seem to me to be too unlike to be placed under the one head.

The majority of writers upon the subject attribute the cause of the eruption to the action of the chemical rays upon the skin. Widmark concludes from his experiments that the ultra-violet rays act with great intensity on the surface of the body.

The difference between the effect produced by the sun's rays in the summer and in the winter in these cases would lead me to believe that their action is not altogether due to the ultra-violet rays, and that the heat rays play also an important part. In my second case the electric light had no effect, although in it the chemical rays predominate. The exclusion of the ultra-violet rays has been accomplished in two or three ways by Unna—by the application of tannate of silica, by

a watery solution of bisulphide of quinine and glycerin, and by curcuma—but the results do not seem to have been very satisfactory. The question arises, How do the rays of the sun produce such deep lesions in so short a time? The process can not easily be explained by direct action on the tissues without the aid of the vaso-motor nerves. The inflammation, then, is probably of a reflex character. Whether any toxin exists in the tissues or not has not been proved.

After reading the description of the recorded cases one arrives at the conclusion that in a very few individuals the sun's rays produce a dermatitis varying in intensity, and accompanied by an eruption which may be vesicular, bullous, or vacciniform. The amount of necrosis and subsequent cicatrization will depend on the vulnerability of the tissues and the amount of exposure.

The second patient, E. F., was very careful not to leave the house when the sun was shining, and this no doubt partly accounted for the absence of cicatrization. The tendency to this form of inflammation does not seem to be hereditary. I have not met with a single instance of its having occurred in more than one member of a family, differing in this respect from xeroderma pigmentosum.

The indications for treatment are twofold: (1) To restore to the tissues that power of resistance which exists in ordinary conditions; (2) so to protect the skin that those rays which would act injuriously are absorbed. In my first case I tried various alteratives without benefit, and internal medication seems to have had very little effect, so far as one can judge from the experience of others.

The protective agents which I have used seemed to irritate the skin, and had not the desired effect of preventing an eruption. A covering which would exclude the light altogether, or almost altogether, was always effectual.

THE INFECTED SCRATCH AND ITS RELATION TO IMPETGIO AND ECTHYMA.*

BY HERMANN G. KLOTZ, M. D.

MR. PRESIDENT: I may owe you an apology for claiming some of your time for a common and trivial affection, particularly since I have nothing to communicate that will be entirely new to you. I believe, however, that the slight skin troubles occurring in daily life deserve our attention just as well as the more

* Read before the American Dermatological Association in Montreal, September, 1895.

rare and interesting diseases, if not for our own sake, in the interest of the general practitioner who is likely to meet oftener with such cases in practice, and who must feel embarrassed if he can not distinctly recognize and denominate the same. It seems to me that in assuming the leadership in the special field of dermatology, we also assume some duties toward the general profession, among them the obligation to so maintain our list of skin diseases that it will enable the practitioner to locate at least the frequent and common affections of the skin under one of its names. But I intend to show that a by no means rare skin trouble, which for the present I shall briefly call the infected scratch, has no legitimate place among the diseases now recognized by the association, and, if admitted into our statistics, enters there under false colors.

The infected scratch is most frequently met with among the patients seeking relief in public institutions, particularly in the dispensaries. It is characterized by the presence of a number of disseminated lesions of different size, bearing either a pustule—that is, a more or less tense elevation of the corneous layer of the epidermis filled with pus—or a dark yellow, brown, or blackish thin crust, or exhibiting a moist surface covered with pus. The pustules are not of a regular shape, sometimes round or oval, often with irregular peripheral indentations; they are usually considerably raised above the skin, tent- or globe-shaped, without a central depression. They do not show any regularity in their distribution, are not symmetrically arranged or formed into groups, but usually discrete, sometimes arranged in chains. Under the crusts, in some instances, a slight loss of substance can be observed extending partly in the superficial layers of the cutis itself, and characterized by a certain infiltration of the basis. In adults the lesions are usually seen on the lower extremities, mostly below the knees, around the ankles, less regularly on the arms, around the wrists, and in the face. Most of the adult patients are males, almost always of unclean habits. In elder children the lesions are mostly found on the face, on the hands, and lower parts of the arms. In small children, while the face is somewhat affected in almost all instances, the pustules are distributed all over the body—hands, buttocks, and lower extremities being favorite seats. The lesions themselves do not itch, but may cause pain by rubbing against the clothes, etc.

Adult patients invariably state that they scratched, without assigning or presenting any particular cause for the itching; that the affected spots bled, then formed dry crusts, and soon after yellow blisters and crusts. In children a history of scratching will always be given. Examination of the patients, which in the first line has to determine

whether pediculosis corporis, scabies, and other parasitic, urticaria, and other itching skin diseases can be excluded, easily confirms the history; scratch marks of various intensity are detected without difficulty, and often the lesions can be observed in their various stages of development—longitudinal dry red marks, then shallow furrows, then single eroded spots of the size of a pin's head or a hempseed, bearing a thin crust; then a small area of raised epidermis with yellow contents, and, gradually extending in height and width, the mature pustule; then the dried-up flat crust, which may have been removed by mechanical irritation, but nowhere and at no time can vesicles or bullæ with serous or seropurulent contents be found.

In some cases no cause for the itching is apparent, except perhaps pressure of tight clothing, the irritation due to hot weather and perspiration. In other cases it is obvious that the patients are not clean in their habits either from necessity or from inclination, or that they are obliged to be on their feet for long hours, often in overheated and dusty rooms. In children, older and younger, the presence of pediculi capitis or their nits can almost invariably be established, although in most instances the skin of the scalp may be perfectly intact and may not show the slightest lesion. At the instance of Dr. S. Pollitzer, my associate in the dispensary service, I have of late paid more attention to this fact, and have been able to confirm it in almost every instance, so that I can not consider it as a mere coincidence. Why the presence of the pediculi on the scalp should produce itching on often remote portions of the body, without affecting the region inhabited by the insects, I am unable to explain. In all such cases the excoriations from scratching and subsequent formation of pustules are the only visible changes of the integument, and apparently the primary and essential symptom. In other cases we find evidence that some other cutaneous lesions have preceded, and have been the direct cause of the itching —urticaria particularly if caused by the bites of mosquitoes and other insects. The restriction of the lesions to portions of the body usually exposed during sleep often indicates the cause of the scratching. In pediculosis corporis, rarely pediculosis pubis, in scabies and prurigo, similar conditions are met with. Here the infected scratch appears as a secondary affection, but quite often as the only one present at the time of observation.

After the investigations of several French authors (Leloir, Dubreuilh, and others), and particularly after the clinical and experimental researches of M. Bockhart (*Mon. f. prakt. Dermatologie*, vi, 450, 1887) there can be no doubt that suppuration in such cases is due to the infection with pus-producing cocci, in the majority with the *Staphylo-*

coccus pyogeneus aureus or *albus* or both. The almost universal distribution of these microbes easily accounts for the frequency of such infections. It is not necessary now to enter into the question how the infection takes place, and what are its immediate effects on the tissues.

Mr. President and gentlemen, I have not the slightest doubt that you well know these cases and instantly and unhesitatingly recognize their nature; but if it comes to the question of giving them a name and bringing them under one particular head, there may be no such unanimity and perhaps some embarrassment if you once go to the trouble of thinking over it. Although itching, apparently without any visible change in the skin, is always the first disturbance, we can not well speak of pruritus where the itching is not chronic or habitual, but, as a rule, more incidental and of a passing nature. We can hardly count the infected scratch under pediculosis capitis if the lesions are found remote from the location of the insects, and this itself remains unaffected. Impetiginous eczema probably is a diagnosis often made in cases of infected scratch, and perhaps correctly so if we are willing to adhere strictly to the teachings of Hebra and his followers, which indeed give very wide limits to eczema. Both affections may greatly resemble each other, and may indeed be combined in one individual, but there is a decided difference. Suppuration is not indigenous to eczema, but whenever it appears it does so as a complication, as a secondary infection with pyogenic cocci. It will be possible in almost all instances to prove that the exudation under the cuticle is originally serous and not purulent, that we have to do with vesicles and not with pustules, while in the infected scratch the pustule forms immediately. Differing from circumscribed lesions within healthy skin, the outlines of the eczematous patches are indefinite, showing a zone of inflamed and slightly infiltrated skin; the itching is much more constant and severe. The eczematous nature becomes still more conspicuous when by some antiseptic treatment the suppuration has been suppressed, usually not a very difficult problem. Then the infiltration, in fact the eczema proper, will remain, while the infected scratch will heal without leaving a trace of a weeping or scaly or infiltrated surface, except perhaps slight redness of short duration. I shall briefly mention impetigo contagiosa, although it is a well-defined disease, invariably beginning with flaccid vesicles, which break down and dry up so rapidly that real pustules are but exceptionally observed.

A name which naturally would suggest itself is that of *impetigo*. If it ever had a definite meaning, it signifies a pustule, a circumscribed elevation of the corneous layers of the epidermis by an accumulation

of fluid contents which are purulent from the very beginning. Besides impetigo contagiosa and herptiformis, which we need not consider, as they are almost generally recognized as diseases *sui generis*, another impetigo is not universally acknowledged. German and Austrian dermatologists since Hebra deny the existence of such a separate disease, different from certain forms of eczema. French authors have not always strictly separated impetigo and impetigo contagiosa. In 1887 (*loc. cit.*) Boekhart again established impetigo as an original disease, and has been able to artificially produce it by inoculations of the *Staphylococcus aureus* and *albus*. His views were confirmed by Unna in 1893 (*Berliner Klinik*), and others in Germany have begun to acknowledge the convincing proof of Bockhart, and to accept his restoration of impetigo. Our own nomenclature has always recognized, and does so now, an impetigo simplex; whether the association has ever officially decided upon a definition of this disease I do not know. But in a number of hand- and text books, some written by members of the association, the authors give a description of impetigo which is based on the views of Dr. L. A. Duhring, of Philadelphia. Some, among them R. Croeker, bluntly state that they accept the existence of such a disease solely on Duhring's authority. Duhring himself defines impetigo as an acute inflammatory disease, characterized by one or more pea or finger-nail sized, discrete, rounded and elevated firm pustules, unattended, as a rule, by itching. The symptoms as described by Duhring are almost identical with those of the infected scratch; but it seems that according to his views the pustules appear spontaneously; he does not mention their formation on previously existing excoriations. Bockhart's description of his impetigo (he calls it impetigo Wilson, Unna calls it impetigo Bockhart) fully agrees with Duhring's, and his clinical and experimental observations clearly confirm the position of Duhring, whom, however, he does not mention. But while he distinctly pronounces the spontaneous appearance of the pustules, he admits another form of impetigo which he calls accidental. "It develops only during the course and as a complication of other itching skin diseases—eczema, scabies, prurigo. Its symptoms are the same as those of the idiopathic impetigo. Its origin is due to the inoculation into the skin by scratching with the nails of the pyogenic cocci which are accidentally present in the scratched skin or under the scratching nails." This accidental impetigo of Boekhart seems identical with my infected scratch, the only difference being that I claim its development not only secondarily as a complication of itching diseases, but primarily as the only abnormal condition of the skin.

Opinions similar to those on impetigo prevail in regard to ecthyma,

the same uncertainty and discrepancy in the description of its symptoms and of its origin. In general, the symptoms attributed to ecthyma greatly resemble those of impetigo; the difference in the cutaneous lesions principally consists in the larger size of the ecthyma pustule, in the inferior tensity and smaller elevation, and in the presence of a slightly indurated basis, due to the deeper infiltration of the tissues, extending into the papillary layer of the cutis, but not deep enough ever to leave a scar. The ecthyma pustule undoubtedly owes its origin to the infection with the same pyogenic cocci; most likely in ecthyma the greater intensity of the local process is due to the impaired general health of the patients and to the influence of bad hygienic conditions. Scratching is admitted to occupy a conspicuous place in the ætiology of ecthyma. In most instances I am inclined to consider ecthyma only as an aggravated form of infected scratch.

If we now look upon the statistics of this association, we find of impetigo, which Duhring and all other authors admit to be a rare disease, from 1877 to 1892 not less than 2,480 cases, or 1·161 per cent; with 1893 added, 2,612 cases. From 1878 to 1887 we have 1,769 cases, or 1·43 per cent, but from 1887 to 1892 only 711, or 0·780 per cent, a decided decrease, which seems to be due in a certain degree to a more strict separation from impetigo contagiosa if we compare the statistics of both:

1877–'92—Cases of impetigo, 2,480, against impetigo contagiosa, 2,106.
1878–'87— " " 1,769 (1·43%), against impetigo contagiosa, 600 (0·485%).
1887–'92— " " 771 (0·780%), " " " 1,508 (1·643%).

The analysis of the statistics of the last five years shows this change in the proportion between the two diseases even more prominently. The numbers of the single years since 1887 show a remarkable similarity in the frequency of impetigo, impetigo contagiosa, and ecthyma, particularly in the small number of cases reported in 1889–'90.

Ecthyma was reported from—

1877–'92..... 1,131 cases = 0·55 per cent.
1878–'87..... 726 " = 0·587 "
1887–'92..... 426 " = 0·467 "

There were reported in—

	Impetigo.	Impetigo contagiosa.	Ecthyma.
1887–'88	144	144	96
1888–'89	170	250	62
1889–'90	33	72	21
1890–'91	101	200	83
One half of 1891	112	442	94
1892	121	523	159
1893	132	268	50

If you consider these statistics, I trust you will agree with me that it is highly improbable, particularly in regard to impetigo, that all the 2,612 cases (including 1893) were actually cases of Duhring's impetigo, and that probably a large number of them were nothing but cases of infected scratch, or of the accidental impetigo of Bockhart, although they strictly are not entitled to be classed as such.

If, then, the infected scratch is not a real impetigo Duhring, nor an eczema, nor pediculosis, nor pruritus, I can not see that it has any legitimate standing among the diseases contained in our official list. But still it exists. Why it ought to be recognized and ought to have a place I have stated before. It could easily be done if we would give a wider latitude to Duhring's impetigo by the admission, besides the spontaneous idiopathic, of the accidental or traumatic impetigo of Bockhart under the name of impetigo simplex traumatica. I am, however, by no means partial to the term impetigo, but should be only too glad to have it entirely abolished, together with others of the old Greek meaningless or misleading names. If it comes to the construction of new names, I unhesitatingly give preference to the attempts of French dermatologists, particularly of Brocq, to establish and substitute entirely new names based on, and apt to directly indicate, the character of the disease as far as it is known, over attempts to resuscitate such names as strophulus, which to the delight of many dermatologists, I trust, seemed to have been buried forever. I do not wish to go into the construction of new names myself, but several times I have come across a term in periodical literature which I should be glad to see generally accepted for the conditions primarily caused by the infection with pyogenic cocci, namely, pyodermia. It would be an easy matter to differentiate between impetigo Duhring and the infected scratch as *pyodermia circumscripta superficialis idiopathica* and *traumatica*. It would not be difficult to further construct similar names for the follicular and for the deep-seated cocci infections which we now know under the names of sycosis, furuncle, carbuncle, and others.

42 East Twenty-second Street, New York.

PROF. BANDELIER'S VIEWS ON HUACOS POTTERY DEFORMATIONS AND PRE-COLUMBIAN SYPHILIS.

By ALBERT S. ASHMEAD, M. D.,
New York.

NEW YORK, *March 29, 1895.*

Prof. A. F. Bandelier, Lake Titicaca, Peru.

DEAR SIR: I am studying the question of pre-Columbian leprosy in Colombia and Peru, and have had an opportunity for studying the huacos pottery which you sent to the American Museum of Natural History. Mr. Saville kindly showed me three specimens, with nose and lip gone; two others, with distorted jaws; another, with amputated feet, etc. But, in all these specimens, hands and feet were perfect. Dr. Muñiz, of Lima, Peru, is inclined to believe that leprosy existed in Peru before the arrival of Spaniards and negroes. He so wrote me. He says that there are evidences of pre-Columbian leprosy on the huacos vases in Peru. Mr. Cushing writes me that he found no evidences of this disease in ancient Arizona, which is of great importance as the ancient Arizonians and the Incas belong probably to the same race. Besides all this, leprosy is almost extinct in Peru, which would not be the case unless there had been perfect isolation, and perfect isolation can only be the consequence of a horror of the disease. If such horror had existed, would they have been likely to bury with their dead representations of the abhorred evil? The representations which I have found on the huacos pottery in the American Museum are, in my opinion, not leprosy, but syphilis; the latter, being a disease of the better classes and a mark of distinction, there would be in the mind of those antique races no indignity in burying syphilitic representations with their dead. If leprosy had existed in South America before Columbus, it could have come from no other place but East Asia, unless we admit, with Brinton and Powell, the autochthony of American civilization; and can we admit the autochthony of such ancient East Asiatic diseases in America as syphilis and leprosy?

Will you be kind enough to give me your opinion as to whether you consider any huacos images as unmistakable representations of leprosy, not syphilis; and will you kindly, if you can, send me photographs of such huacos pottery as represent in your opinion leprous lesions? Will you also allow me to take photographs of such huacos deformations as are in Mr. Saville's hands? I should, moreover, be obliged to you if you would inform me if the clay image of the foot,

natural size, in Mr. Saville's hands, is to be considered huacos pottery, and whether it is pre- or post-Columbian.

I shall be immensely obliged if you will confer these favors on me and assist me in my studies with any other advice which you may deem useful. I have the honor to be your most obedient servant,

ALBERT S. ASHMEAD.

Prof. Bandelier, the explorer of the American Museum of Natural History, sent me the following letter; it corroborates all my conclusions regarding pre-Columbian leprosy.

They are: 1. The deformations on figures represented on pre-Columbian huacos are syphilis and lupus. 2. There is no positive trace of pre-Columbian leprosy. 3. Tuberculosis (lupus) and syphilis have certainly existed and flourished in pre-Columbian America.

Here is the letter:

LA PAZ, BOLIVIA, *September 6, 1895*

Dr. Albert S. Ashmead, New York City.

DEAR SIR: Your letter of inquiry, dated March 29th, reached me on the island of Titicaca in Bolivian waters on the 13th of May. I was then and have remained until a few days ago unable to attend to any but the most indispensable and most concise correspondence, as my right arm is invalidated by writer's cramp in the highest degree, and I had no typewriter then at my command, the one which I brought to Bolivia having been wrecked last year, and the typewriter on which this is written arriving only last July, and even then greatly damaged through the imbecility of the Bolivian custom-house employees. The machine is now fairly in order again, and this is the second letter for which it is used. You will thus understand why your communications have not been replied to at an earlier date. Besides, the islands of Titicaca, etc., are so inaccessible that months and months may elapse sometimes ere one can receive or send postal matter. No adequate idea is held in the United States of the difficulties accompanying life on those secluded isles, which no steamer touches unless by special permission, and where we remained at one time three months and a half without seeing any kind of craft whatever, the indigenous *balsa* not excepted.

I am glad that some of the collections which the American Museum has received through me have proved to be of some service to you, and, ere I reply to your inquiries, must state that through the kindness of our excellent friend here, Minister Moonlight, I have been able to peruse your treatise on pre-Columbian leprosy, which has been a

source of both pleasure and profit. Permit me, however, as a preliminary remark, to inquire whether the bones which you mention in the terminal note as having come from "Llujon, Bolivia, five miles over the Peruvian line," are perhaps some of the bones which we sent from Llujo. If this should be the case, then you have been misinformed in regard to the location of the site. The Lluju or Llujo which we explored in Bolivia lies very far to the southeast of Tiahuanaco, at the foot of Illimani, and correspondingly distant from the Peruvian border. Its ruins stand in no relation whatever to those of Tiahuanaco. This, in case that it should be "our" Llujo, and not another locality called Llujon, of which we have as yet no knowledge.

I have not with me my journal of the year 1892, and hence can not furnish you with the information touching the Pachacamac foot as detailed and positive as I would desire. But I recollect that the specimen, which at once attracted my attention in the highest degree, was obtained from the great burial place at the foot of the partly artificial mound on which, according to Miguel Eztete, stood the adoratory of the idol or fetich to which the name Pachacamac had been given, and at a considerable comparative depth, say ten or twelve feet beneath the surface. That it is not only pre-Columbian but also the work of the coast people (not Inca nor of mountaineers in general) there can be no doubt. All the Pachacamac remains, a few specimens perhaps excepted, which I can not now remember, belong to the so-called Yunca or coast-Indian type of artefacts, and they are certainly anterior in date to 1532. I do not wish to be understood to say that *all* the Pachacamac finds to be made, or made previously, are *not* post-Columbian, but the site where I caused the excavations to be made, and the depth at which the objects were taken out, point to the conclusion that my finds are indeed pre-Columbian, or at least with very few exceptions only. The human foot, alone and in appearance amputated, is not rare among coast pottery, and the museum must have another one sent by me from Lambayeque, with its sandal and perfectly normal, as well as handsomely imitated in black clay. I remember having seen other specimens of the same description. But none of them were deformed, as the Pachacamac foot is.

I have heard of the existence of leprosy on the Peruvian coast, but as isolated cases only, and have seen at the hacienda of Villa, near Lima, one case of elephantiasis. The patient was a negro or mulatto—which, I can not recall. But the disease is certainly rare, and I have heard it mentioned as of recent origin, and even attributable to the importation of Chinese to Peru. Of ancient leprosy I have no knowledge, but would strongly recommend consulting Cieza de Leon and

especially the book of Father Cobo, S. J., *Historia del Mundo Novo* on the subject. I am here out of the world, so to say, in regard to documentary sources of information, and can only direct attention to such of them as my recollection points to as possibly bearing on the subject. At Lima, where I reside, I could tell more. In the Sierra there are a number of skin diseases (see Tschudi, *Peru*, 1842) that not infrequently result fatally by penetrating (so is the popular version and terminology) to the bone. Thus I have seen on the plateau of Cajamarca, and especially on the eastern slope of the Cordillera of northern Peru and beyond the Rio Marañon, in Chachapoyas, a disease called *uta*, that is not incurable as long as it maintains a certain light character, but leaves indelible marks on the skin; not only coffee-brown blotches, but the whole surface affected remains depressed thereafter, even when healed. The people of these sections speak of a much worse kind of the same disease, one that gradually "eats skin, flesh, and bone," and which is regarded as incurable. I never saw a case of it, but my residence in the valleys between the Marañon and Huallaga was not of long duration, and furthermore I have no knowledge of the science of medicine, nor of any of its particular branches. Descriptions also vary a great deal. In the hot regions of Bolivia, as Apolobamba and the Beni country, a skin disease known under the name of *espundia* exists. I say skin disease, as thus it is qualified by the people. From descriptions it seems to be at least very similar to the *uta*. It is also fatal, at least sometimes. I am informed by a friend who has resided for a number of years at Cochabamba, in southern Bolivia, that leprosy exists there, or some disease which is called *lepra* by the inhabitants. I have not yet been able to inquire of members of the Bolivian faculty concerning such matters.

Syphilis and related infirmities are common everywhere, and among Indians as well as among any other portion of the inhabitants. The disfigured faces on the pottery are generally regarded as representations of that disease, and I never heard leprosy mentioned in connection with them. In addition to the kind of vases representing such phenomena, other ones are found of a still more obscene character, and one of them I sent to the museum from Chan-Chan, showing man in connection with the llama. That *all* such ceramics are pre-Columbian can not positively be asserted, and I can not guarantee, for instance, that all the vases sent by me from Chimbote antedate the advent of Pizarro. But this much may safely be admitted, that the *types* of the designs are pre-Spanish, and that whichever vase be posterior to the occupation of Peru by Spaniards, is only an imitation of models in use long before, except, of course, such as show clearly

European influence. In other words, the idea of copying on ceramics the effects of syphilitic affections upon human faces is without any doubt pre-Columbian in Peru, and was carried out on numerous specimens long before the white man ever landed on the Peruvian coast in the sixteenth century.

After the organization of these countries under the laws of Spain, the natives did not change customs and art forthwith. The change came gradually. Thus the modes of burial of pre-Columbian times were still extensively practiced in the seventeenth century. Else, why the works of Arriaga on the *Extirpacion de la Idolatria*, and of Villa-Gomez on the *Exortacion de la Idolatria*, from about 1630. These highly important books describe a large number of aboriginal practices in vogue at that time. That even quite a number of vessels representing syphilitic diseases should be post-Columbian is therefore only a proof of the fact that they are survivals of artistic ideas carried out long previous to the Columbian era, and that hence the disease existed in Peru untold centuries ago as well as it exists to-day.

I have not, as yet, seen any ceramics of the kind in the mountain regions, but this does not disprove their existence. Some may come to light unexpectedly, or may be known to others, whereas I have not learned of their existence. I would call your attention to the collections lately sent by us to the museum from the islands and shores of the lake, which contain over a hundred skulls, etc., and among which you might perhaps also find some useful material.

As we are on the point of leaving for the Illimani again, afterward to return to Lima for the summer, it would be useless to write to me here or any other point in Bolivia. A letter directed to me: "Casilla (letter box), No. 303 at Lima, Peru," is sure to reach me there. I have the honor to remain very respectfully yours, Ad. F. Bandelier.

Permit me to call your attention to the possibility of the existence, on Peruvian vases, of representations of the mark of the "uta" on the arms, chest, and thighs of a human figure; also on the faces. I do not recollect having seen any, but as the disease is also met with, though quite rarely, in valleys on the *western* slope of the Cordillera, it is not impossible that it might have been copied. You might also bear in mind that the so-called *verrugas* exist in the upper part of the *Rimac* Valley, and that both of these affections, if copied in clay, can mislead as to the nature of the disease. Thus marks of the *uta* might be taken for leprosy when imperfectly copied.

Again, let me call your attention to a number of ancient works on Peru, as possibly containing information: Acosta, Oviedo, the early

reports on the first years of the conquest, like Xerés, Eztete, Hernando Pizarro, the somewhat later one of Pedro Pizarro, and even Gomára.

In this letter the writer admits that *verruga* and *uta* may be represented with syphilis. The following descriptions of the first two diseases I have taken from the *Climatologie médicale* of South America, by Dr. Samuel Gaehe (Buenos Ayres, Marrieno Moreno, Calle Corriente, 829, 1895):

Verruga, which is called now Carrion malady, is endemic, and peculiar to Pern, where probably the Ineas have known it. It acts principally in certain cañons, like Huarochiri, Yanyos, and Cauto. Tschudi made of it, in 1843, a description of which we reproduce several paragraphs, the more important: "In several of the valleys of the road which goes from the shore to the mountain, especially in the valley Surco, there are certain springs of which the Indians never drink the waters. When a stranger approaches them to quench his thirst, people cry to him, 'It is verruga water!' It is not even allowed to horses or to mules to refresh themselves in these springs, of which it is supposed the waters have the effect to produce this disease. As the existence of that evil is not known in any other country, there is apparent reason to believe that it has its origin in certain local circumstances. The verrugas manifest themselves by pains in the throat, in the bones, and by various febrile symptoms. After a few days an eruption of verrugas appears on the body; they are of red hue, they develop themselves, and some of them attain the size of an egg. The blood flows off in such abundance that the forces of the patient are exhausted and consumption supervenes. The little verrugas are those which produce the greater quantity of blood, and I have seen an Indian of middle race who had lost two litres. I can only connect this disease with the cause assigned by the Indians. In all the circumstances, it is certain that those who abstain from drinking the waters of the condemned springs escape the verrugas, while those who have tasted these waters only once are attacked by the disease. The same fact shows itself with the mules and the horses. This affection is rampant in the village of Santa Olaya." (*Discours lu par le Dr. David Matto, Président de la Société médicale, Union Fernandina, dans la séance du 5 octobre 1886.*)

In 1858 Dr. Odriozola and Dr. Salazar, cited by Dr. Matto, undertook some studies on said disease, and arrived at this conclusion: That it recognizes a special principle as generator, and that the water of the springs situated on the west slope of the Andes serves as vehicle to it. They showed the seat of the verruga in the province of Huarochiri

especially in the village of Santa Olaya, and they gave a description of it, recognizing two forms—one tuberculous, the other globular.

Some later works have advanced the knowledge of this subject, until, in 1873, Dr. Enrique C. Basadre pushed these studies a considerable step forward in admitting that the verruga was produced by a special poison, probably telluric, and consisting of bacteria. Referring, himself, to the entity of this affection with the "fever of Oroya," he says: "One knows that the travelers on the railroad of Oroya are attacked by a very grave fever, of a typhoid character, whose incubation is short, and which is probably no other than a grave form of the disease of the verrugas, in which disease the eruption does not come to the point of producing itself."

Later appeared new conquests. Puchna Tupper, in his thesis *La Verruga Peruana* (Berlin, 1879), and Izquierdo, who, in a work, *Ezquisomicetas de la Verruga Peruana*, gives his opinion and condenses it in these words: "The vegetations of the verruga of Peru are conjunctive neoplasms which develop themselves always in the skin of the subcutaneous cellular tissue. From an anatomic point of view they differ completely from the common verrugas, and present a great analogy in structure with the sarcomas. There is also a variety of *schizomycetes* which exist in great numbers, as well in the interstices of the anatomic elements, cellular and fibrous, and also in the vessels which it obstructs completely. These same *schizomycetes* fill the arterial and venous capillaries of the sound skin, as well as of the subcutaneous tissue, in the zone which is near the neoplastic vegetations. The bacterium in question presents itself under the form of a bacillus which measures from 8 to 12 μ in length, and exceptionally 20, and which is a little bigger than that of tuberculosis. The rods of medium dimension are provided with small eminences or nodosities, more apparent in the bacilli of large dimension" (Virchow's *Archives*).

According to Dr. Matto, until the moment when the workmen on the railroad of Oroya commenced, only the physicians of the hospitals had knowledge of an *anemiant* fever which attacked persons who at this time traveled in the cañon of the Rimac, going up it. The negroes who carried the sacks of silver of the mountain of Pasco, in traversing the province of Huarochiri, returned sick to the hospital San Bartholomew, with a continued fever, tenacious, which nothing could alleviate: fever *anémiante*, rebellious to all treatment, which followed its course in destroying the red corpuscles until it had killed the unfortunate whom it attacked, to the great despair of the physician, who in his ignorance could not render himself an account at the pillow of his patient of so grave a pyrexia. In the opinion of the physicians of this

period, the negroes attacked by this affection became white, they died exsanguinated, and this fact made plain the state of anæmia characteristic of this disease. At the occasion of the building of the railroad of Oroya the number of patients increased, and the hospitals of Lima and of Callao were filled with the victims of what was called "fever of Oroya," whose mortality was considerable. In searching for an explanation of its origin paludism occurred, and some attributed to it the special character of the fevers provoked by the digging up of the soils.

In order to dissipate the doubts on the question whether the verruga was infectious and inoculable, Daniel A. Carrion, a student of the sixth year, presented himself to an inoculation, which was practiced on him the 27th of August, 1885, by Dr. Evaristo M. Chaves, by means of blood which had just been extracted by scraping a verrugous tumor, of reddish color, situated on the right superciliary region of a patient of the service of Dr. Villar. In the course of the disease, experimentally determined, and which prolonged itself until the 5th of October, Carrion presented the following symptoms: Twenty minutes after inoculation there was produced a slight itching, tolerably sensible, followed by passing pains, which disappeared two hours later. Until the 17th of September he felt nothing; on that day he felt during the evening a light *malaise*, and a pain in the left tibio-tarsal articulation; the next day the body collapsed. The 19th the *malaise* increased; cramps, nervous collapse, short and repeated chills, with chattering of the teeth, fever very high, pains general over the whole body, headache, pains in the thorax and in the abdominal parietes, sleeplessness, diarrhœa; temperature, 39·4° C.; urine red, black, sedimentous, and scanty.

The patient continued in these conditions until the 24th, when he appeared a little relieved as to all these symptoms. Afterward sweatings presented themselves, pains in the eyes and in the articulations, considerable pallor of the skin and mucous membranes, pulse feeble and frequent, faint and soft murmur at the base of the heart (with the first sound), respiration normal, anorexia, great feebleness, profound and intermittent pain in the right hypochondrium, swelling of liver, vomiting, vertigo, eyes dark-ringed, haggard face, cheeks and temples entirely sunken, discolored mucosa, urine scanty and desire to urinate frequent, loss of memory, on some occasions extreme agitation, pain in the epigastrium and in the precordial and saeral regions. The patient continued thus until October 3d. The morning of that day he declared that he felt better, but his state was the following: Sleeplessness, voice difficult, slow, and sometimes extinguished, respiration irregular, skin dry and cold, picking at the bedclothes and bowel incontinence, incontinence of urine, which is abundant. Dr. Flores examined

with the microscope the blood of the patient, and observed that the red globules were deformed, and their number was 1,085,000 per cubic millimetre; the white corpuscles were numerically augmented in proportion to the hæmatics. In this state it was decided to practice transfusion of blood, an operation which was postponed. The next day the intelligence is enfeebled and is almost completely lost. The 5th, at nine o'clock in the evening, the patient went into coma; the pupils dilated, pulse threadlike and hardly perceptible; tracheal râle. At 11.15 he expired.

M. Alcedan, to whom we are indebted for all these details, proposed, at a public demonstration in honor of this noble victim of the love of science, to give to the verruga the name of Carrion disease.

In consequence of these experimental studies, consecrated by the termination of the observation made upon that intrepid martyr of science, Dr. L. Avendaño has arrived at the following conclusions:

1. Verruga must be considered as a zymotic disease of the telluric group, beside malaria, cholera, yellow fever, etc., and as such one must believe by analogy in the existence of a special micro-organism which produces it.

2. It is inoculable—that is, transmissible from man to man; however, there are not reasons enough for saying that it is contagious.

3. The morbid state known by our physicians under the erroneous name of fever of Oroya is not a distinct morbid entity, but only the febrile period which precedes, in the grave cases, the eruption of the dermatosis, which never completes itself before death supervenes, as a consequence of profound trouble of the organism by the complete alteration of the blood upon which the germ productor of the disease principally exercises its action.

Lupus, known under the name of *uta*—a name which comes from the corruption of the Quechua expression *uza* (which signifies louse)—is endemic in Lima, Jaso, Andamarca, Ayacucho, Malvas, Tingo, Marcara, Pampas, Cataparaco, and other departments of the interior.

Orrégo describes it thus: The uta is a disagreeable wound which develops itself at certain periods of the year and in the valleys where one meets certain venomous insects. It is of two kinds—one is *aquatic* and of short duration, the other is dry.

Dr. Ugaz has made of it a special study, and as a result of his experimental and clinical studies he says that uta has for its cause the bacillus of tuberculosis; the cutaneous and pulmonary progress is identical, and presents no other difference but the vital importance of the integument interested.

Speaking of the manner in which it behaves in the organism, he

adds: In this insensible ulceration, without pain, mostly neglected, the miero-organism has multiplied and metamorphosed itself in silence; it has established a colony which, after vegetating long months and compromising the nearest tissues, continues by forming a new tubercle, then several others which, once united, constitute the variety of the *lupus hypertrophica* (dry uta); when they have grown up, they gain the vascular lymphatic ways, always free to provoke the same process from distance to distance, like the beads of a rosary (*lupus serpiginoso*); finally arrives the hour of regression, the adult inhabitants of a colonial group die, and their spoils are taken off with an albuminous, sanguinolent liquid in order to characterize the third form (*uta aguada*), *lupus ulceroso.*

If they are not stopped in their march they continue to conquer territories more and more important for life, until the auto-infection transforms the man into an ambulant, redoubtable focus of millions of pathogenic beings (general tuberculosis).

Ugaz presents the following deductions and observations from his works:

1. The uta of Peru is a bacillary tuberculosis localized generally in the parts of the skin which are uncovered.

2. It is endemic in certain cañons of both slopes of the Andes.

3. Its genesis is subordinate to the meteorological conditions by the physical and mechanical causes which insure the epitheliums; its evolution depends on the dispositions—diathetic and anatomo-physiological—of the individual.

4. Its treatment is endermic or surgical only.

Dr. Villar believes that, although from a point of view anatomo-physiologic there is identity between tuberculosis and lupus, considering that on both sides the original element is the bacillus of Koch, and that the inoculation of the lupous substance produces tuberculosis, one must yet take into account the fact that the lupus is endemic in certain regions of the mountain where pulmonary tuberculosis is very rare, and even does not exist, in the regions where the consumptives come from the coast to recuperate their health; that lupus seems to be produced by a local cause which, following a general belief, is the inoculation of the poisonous secretion of a spider (*uta ó tac—araña*) which settles itself upon the uncovered parts of the body like the face; that the lupous one is not tuberculous; that for lupus alone the treatment consists in every period in the application of local means, like cauterization; that, softened and infiltrated, it does not acquire the qualities of an inoculated tuberculosis. (Discourse of Dr. Villar *en prenant la présidence de l'Academia Nacional de Medicina de Lima.*)

Society Transactions.

THE NEW YORK DERMATOLOGICAL SOCIETY.

Two Hundred and Forty-seventh Regular Meeting, held on Tuesday Evening, November 26, 1895.

Dr. C. W. Cutler, *President, in the Chair.*

A Case for Diagnosis.—Presented by Dr. George H. Fox.

D. M., male, a mounted policeman by occupation. On November 3, 1895, he was struck on the nose and lip by a horse's head. The nose bled and was slightly abraded. On November 10th, when he had almost recovered from his injury, it suddenly grew worse, and when seen on November 19th there were crusted pustules on the nose and upper lip, with œdema of the left cheek. From the appearance of the man's face, and especially from the fresh vesicular lesions on the cheek, a diagnosis of contagious impetigo was made, and mercurial plaster applied. On November 22d it was found that the lesions, instead of healing, had rapidly developed into rounded tumors of a soft, spongy, fungous character, which readily bled. Under the use of nitrate of silver and a solution of carbolic acid (sixteen per cent) the eruption has improved.

Dr. Fox said the case was a unique one in his experience, and the lesions appeared to be the result of wound infection while healing. The patient stated that he remembered applying vaseline which had been used on horses ; he also applied some witch hazel from a bottle intended for equine use.

Dr. George T. Elliot said he regarded the lesion on the man's face as a granuloma ; it was similar to what in former days was known as "proud flesh" in a wound ; that is, granulation tissue which is the result of wound infection. Such lesions can be readily cured without leaving a scar by simply painting them with tincture of iodine or a ten-per-cent solution of permanganate of potassium for a week or ten days.

Dr. Fox said the lesions at first were almost typical of impetigo contagiosa. Inasmuch as observers have reported that the micro-organisms found in recent vaccination crusts are identical with those found in impetigo contagiosa, the speaker inquired whether any of the members present had seen any connection between these two conditions.

Dr. Elliot said that in impetigo contagiosa the *Staphylococcus aureus* and *cereus* have been found in some cases, and in others the *Staphylococcus albus*. Whether these same micro-organisms can give rise to granulation tumors, and also to a bullous formation which becomes pustular in character and has a tendency to spread over the surface, can not yet be said to be settled. The granulation tumors may possibly be due to an entirely different micro-organism, one which has no connection whatever with those found in the lesions of contagious impetigo, or of other processes.

Dr. S. Sherwell said that in these granulating tumors he had seen marked benefit follow the use of the acid nitrate of mercury, pricking it into the unsound tissue at various points with the moistened end of a probe or toothpick.

DR. H. G. KLOTZ suggested that the trichophyton might be present in the lesion, and referred to its kerionlike appearance. The presence of this fungus could be easily explained, as the man received his injury from the blow of a horse.

DR. E. B. BRONSON said he did not think it necessary to assume that the fungating character of the lesion in that case was essentially due to any specific infecting cause. It was more likely that there existed a predisposition in the tissues themselves to fungate when ulceration took place. We saw this frequently in syphilis.

DR. J. A. FORDYCE said he did not think that the condition met with in this case was due to any one specific cause. Similar conditions are produced by chemical agents, or by certain drugs taken internally. He was inclined to agree with Dr. Bronson that the fungating character which some lesions assume was due in a measure to individual predisposition.

DR. S. LUSTGARTEN said he agreed with the diagnosis of infectious granuloma. That it is infectious is only suppositional, but it must be borne in mind that we see these growths almost exclusively in infectious diseases, such as syphilis, tuberculosis, etc., and by analogy we are justified in suspecting an infectious origin in this instance. Moreover, in this case we get a history of traumatism, and this makes it still more probable that we have to deal with an infection. It would be interesting to learn the result of a microscopic examination. As suggested by Dr. Klotz, this would possibly disclose the presence of the trichophyton. So far as the ætiology of impetigo contagiosa is concerned, it is still undecided. In his own investigations on this subject, made several years ago, he got a pure culture of cocci which he was unable to distinguish from the *Staphylococcus albus*, and which he inoculated on himself with only partial success.

DR. SHERWELL suggested the term inflammatory fungating neoplasm as an appropriate one for this lesion, as one being truthful and at the same time non-committal.

DR. ELLIOT said he did not agree with those speakers who thought that the fungating character of these lesions was due to a peculiarity of the tissues of the individual. He had seen similar lesions develop in persons of all ages—in children as well as old people—and from scratches, wounds, or in connection with some cutaneous process. There was certainly no reason to seek for any inherent peculiarity of the tissues when there were many external factors which might give rise to the same thing. Moreover, he would call attention to the fact that Dr. Fox's patient presented the granulomata and, a short distance from them on the face, raw-looking, scratched lesions without any granuloma formation. It seemed to him that if the cause of the tissue proliferation was some inherent peculiarity of the tissues, then all the lesions on the patient should show this peculiarity, and the condition not be one limited to some few.

DR. P. A. MORROW said, in reference to the point suggested by Dr. Bronson, that he was inclined to believe that there are certain conditions or properties inherent in the tissues of certain individuals which determined the form or physiognomy of lesions. This was manifest even in skin diseases which we recognize as due to a specific germ—the character of the eruption is determined largely by the soil. In syphilis, for example, the type of the disease is largely the product of peculiarities of individual constitution. We

note in certain cases of syphilis a tendency to excessive scaliness; in others a tendency to the production of pustular lesions is so marked as to indicate a pyogenic proclivity on the part of the patient. The wide variations in the type of the morbid process we recognize as due not to the nature of the syphilitic virus, but to certain localizing influences inherent in the tissues. In Dr. Fox's case it is possible that the secretions from the man's nose may have had something to do with infecting the lesion. We know that in syphilis and lupus there is a special tendency to exuberant granulation in lesions located about the nose and upper lip.

Dr. Klotz said that some years ago Hamilton, of Edinburgh, in a paper on sponge grafting, published in the *Edinburgh Medical Journal*, explained the production of these fungous granulations by the fact that when the protecting epidermis is taken away the capillary loops in the papillæ can not offer sufficient resistance to the force of the blood pressure and become elongated; afterward the connective tissue forms around the blood-vessels as a support.

Dr. Elliot said that Dr. Morrow in his remarks referred to exuberant granulations met with in lupus. It is now six or seven years ago that the fact was established that the tubercle bacilli never produce suppuration; that we can have no suppuration excepting when the pus cocci are also present. In the hypertrophic form of lupus the pus cocci are present and we have a great proliferation of granulation tissue. If this granulation tissue were simply due to a peculiarity of the tissues of certain individuals, we should see them much more frequently than we do, and, as a matter of fact, it is exceptional to see them. If we accept the theory that they are due to a peculiarity of the system, we are going back to the days when we knew nothing about mycology or bacteriology.

Dr. Morrow asked Dr. Elliot to explain, if he could, why it is that a certain drug—copaiba, for example—will produce an eruption in one case, while in perhaps a hundred other cases in which the drug is given in the same doses it will produce no such result. He did not see how this could be explained, excepting on the ground of some peculiarity of the tissues which predisposes them to such an eruption. While we can not explain an idiosyncrasy of this kind, we must admit that it exists. It is the only explanation we can give of many such anomalies.

Dr. Elliot said that Dr. Morrow, in referring to drug eruptions, was speaking of something entirely distinct from microbic dermatoses. He would ask Dr. Morrow, however, why in his book on *Drug Eruptions* he makes the statement that a bromide eruption is due to an *exaggerated* action of the drug, and does not refer it to inherent peculiarity of the tissues. Why should a fungating bromide eruption be simply an expression of an exaggerated physiological action, while a granuloma is due to an inherent peculiarity of the tissues?

Dr. Morrow said that in his book on *Drug Eruptions* he certainly makes a distinction between common *specific* eruptions, in which a certain drug produces what might be termed characteristic or specific action on the skin in a large proportion of all cases in which it is administered, and incidental or anomalous eruptions, which are not characteristic, are of rare occurrence, and entirely incidental to the action of the drug. This, however, has no bearing on the question of whether or not there may exist a predisposition

in the tissues of certain individuals toward the development of eruptive troubles.

DR. LUSTGARTEN said he regarded Dr. Elliot's position as entirely too radical. At present the factor of individual predisposition can not be eliminated in explaining different forms of eruption due to the same cause.

DR. FOX said he did not think a drug eruption, such as is produced by copaiba, is due to any inherent tendency of the skin. The eruption is practically an erythema multiforme, such as we often see arising spontaneously. Suppose we are giving copaiba in large doses to one hundred patients; of these, let us assume that one or two are about to develop an outbreak of erythema multiforme spontaneously; the copaiba simply acts as the exciting cause and the eruption appears.

Dr. Fox said he did not agree with those speakers who likened the lesion in his case to kerion. It was too superficial. The granulations in growths of this character and in vaccination tumors, as occasionally seen, are probably due to some mycotic process. Some years ago Dr. Piffard claimed that the micro-organisms found in vaccination crusts and in the lesions of impetigo contagiosa were identical. In the following case, coming under the speaker's observation, this theory seemed to be substantiated: A physician, after vaccinating a child, put his lancet in his overcoat pocket, and afterward, in putting his hand in his pocket, he accidentally pricked his finger. A short time afterward a typical lesion of impetigo contagiosa developed at the site of the wound on the finger.

If these fungating tumors, such as this man presents, are due to any condition of the tissues, why do we not see them in other parts of the body where the skin is abraded? The speaker said he was inclined to attribute them to some mycotic process rather than to a predisposition of the tissues.

DR. BRONSON said he did not assume that these fungating tumors could develop *de novo* just because of the peculiarity of the tissues, but rather that the exuberant granulations appear after a certain degree or kind of irritation, though the same irritations would not cause lesions to fungate under ordinary conditions of the tissue. It is a well-known fact that in different individuals the same irritant, whether infective or not, will produce very dissimilar effects. We see this in the action of the chancrous virus on different individuals. This same virus, which in one person causes a comparatively small, circumscribed ulcer, may in another person give rise to a diffusely spreading phagedena. This difference is entirely due to peculiarities of the soil.

A Case of Vitiligo.—Presented by DR. SHERWELL for DR. MORTON.

The patient was a young colored girl, fourteen years of age, with very extensive whitened patches of skin in various regions of the body, including the face, neck, and particularly the lower limbs. The changes in the color of the skin were first noticed about four years ago, the lower limbs being first attacked. The girl enjoys excellent health. The case was shown as being interesting on account of the extent of the lesions.

DR. C. W. ALLEN referred to a case of vitiligo coming under his observation where the skin on the neck and bosom of a young colored girl was perfectly white. In another case seen last summer at Long Branch the backs of the hands and arms and the body generally showed white areas, which in the aggregate equaled or exceeded those of this case.

DR. FOX said that many of the text-books, in describing this disease, refer

to a dark margin around the advancing border of the leucodermatous patches. Such a margin, he thought, is rarely seen, but the entire skin in the neighborhood of the patches is apt to assume an intensified color.

Dr. Morrow expressed the opinion that none of these patients ever become entirely white. Some years ago he saw a colored boy who presented numerous large areas of whitened skin over the entire surface, but vestiges of the normal pigment remained. He was doubtful whether the darkened margin which is observed surrounding these light patches is really due to an actual increase of pigmentation at the border or is the result of an optical illusion. He had often fancied that this increased pigmentation was apparent rather than real.

Dr. Bronson said he did not agree with Dr. Morrow, but believed that there was a veritable increase in the pigmentation at the periphery of the patches. He inquired if it had not been the general experience of those present that the affection is much more commonly met with in the mixed races than in the pure blacks.

Dr. Morrow said he had seen it in coal-black negroes.

Dr. George T. Jackson expressed the view that the increase in pigmentation was real and not apparent. In a case recently seen at the Vanderbilt Clinic, in which the neck and face were the parts affected, the skin about the white patches was so much darker than that on the rest of the body that the question arose whether the case was one of leucoderma or chloasma.

Dr. Elliot said it had always seemed to him that the color of the skin about the periphery of the patches was darker than the normal.

Dr. Fordyce also believed that there was an increase of pigment at the periphery; this seems to be the result of a displacement of the pigment.

Dr. Fox inquired whether any of the members had observed cases in which the spots disappeared spontaneously. He had noticed in many cases that the spots were not noticeable in winter but reappeared in summer, when the hands are tanned by the sun. In one case coming under his observation a spontaneous cure seemed to have taken place. As regarded treatment, he has tried plasters and mustard applications, and even staining, without any success.

Dr. C. W. Cutler inquired whether the members made any distinction between vitiligo and leucoderma. Dr. Elliot, he thought, once made such a distinction.

Dr. Elliot said that personally he always regarded leucoderma and vitiligo as being the same thing. Dr. Piffard made the distinction that in one affection the patches enlarged while in the other they remained stationary; the speaker did not see why this distinction should be made, as in a case seen at one time the patches may be spreading, but at another cessation may have occurred and the patches are stationary. Under such circumstances is the same case at one time vitiligo, at another leucoderma? He thought that the loss of pigmentation on the sites of former lesions should be rather termed achromia of this or that origin—syphilitic, etc.—rather than leucoderma.

Dr. Bronson said he had always regarded the existence of leucoderma as an independent form of disease as purely theoretical. He is doubtful whether such a disease, pure and simple—that is, simple idiopathic loss of pigmentation of the skin without pigmentation of the border—exists. At least, he had never seen such a disease.

DR. MORROW said he made no distinction between leucoderma and vitiligo, nor did he believe that any existed. As regarded treatment, he had in one or two instances seen decided improvement follow the continued application of mustard and other irritants to the whitened patches with the use of electricity. In one case the whitened patches entirely disappeared under this treatment. He was unable to say whether the improvement was permanent, as the patient was lost sight of. In some cases of vitiligo the patches disappear spontaneously.

DR. BRONSON said he regarded leucoderma as simply a disease condition, not a disease—a condition present (albinism) in the central portions of the disease (vitiligo)—and also as a secondary effect in many other lesions of the skin, such as cicatrization. There was a well-recognized affection, characterized by a certain complex of symptoms and a more or less definite course, which had long been known as vitiligo. Of that leucoderma was but one symptom.

DR. ELLIOT said albinism is entirely distinct from leucoderma. Albinism is always congenital, and we have the characteristic color of the hair and iris. These changes are absent in leucoderma, which is an affection that is likely to appear at any age.

DR. LUSTGARTEN said he was inclined to agree with Dr. Bronson. If the difference between leucoderma and vitiligo is not pathological, it is at least nosological. By the term vitiligo a distinct picture is brought to our minds of a disease which consists of a loss of pigment in certain areas of the skin; these areas increase in size and finally come to a standstill. In leucoderma, as a rule, we know there is a loss of pigment due to some inflammatory process or application. It is not a disease, but a condition following a disease.

DR. SHERWELL said he agreed with Dr. Morrow that these patients never get entirely white. In one case of vitiligo coming under his observation, considerable improvement followed the use of the bichloride of mercury, used externally and in considerable strength. In albinism the loss of pigment in the eye is usually most pronounced in the layers of the choroid—the uveal tract.

A Case of Copaiba Eruption.—Presented by DR. FORDYCE.

The patient was a young man who had syphilis one year ago. At present he has no evidence of that disease. Two weeks ago he became deeply jaundiced, and about a week later he developed an erythematous eruption on the flexor surfaces of the forearms and hands. When this eruption appeared he had been taking the Lafayette mixture for a week or ten days, and the copaiba which this mixture contains is probably responsible for both the eruption and the jaundice.

DR. ALLEN said that in Dr. Fordyce's case the eruption seemed to follow the course of the nerves more closely than he had ever seen it do in the copaiba eruption, which also usually appears over the trunk. He thought, however, it might be an anomalous instance of copaiba eruption.

DR. FOX said he did not think there was anything characteristic about a copaiba rash. He had seen a multiform erythema evoked by the administration of this drug. It is more apt to occur on the flexor surfaces than on the backs of the hands, where an erythema multiforme usually appears.

DR. MORROW said the only peculiarity he noticed about the eruption was its location. While copaiba eruptions have certain regions of predilection,

notably the wrists and ankles, they are apt to be more generalized and not limited to the upper members, as in this case.

Dr. Klotz said the patient stated that the eruption came out a week after he stopped taking the Lafayette mixture. This would make the diagnosis of copaiba eruption rather doubtful.

NEW YORK ACADEMY OF MEDICINE.

Section on Genito-Urinary Surgery. Stated Meeting, held on Tuesday Evening, December 10, 1895.

Dr. Alexander W. Stein, *President, in the Chair.*

A Case of Double Tubercular Epididymitis.—Presented by Dr. Samuel Alexander.

The patient was a young man, who first noticed in January, 1894, that his left testicle was swollen. There was slight pain. From the 1st of February to the end of March he applied an ointment, which he believes was blue ointment, and took internally a medicine, which he believes was potassium iodide. This was probably prescribed by his physician on the supposition that the condition was due to syphilis, because a year previous to that time he had had a soft sore on the penis which healed, after cauterization, without further symptoms. Early in May, 1895, an abscess developed in the right side of the scrotum, which was lanced, and this had been discharging up to the time he came under the speaker's observation. An examination at this period showed that the epididymis on the left side was hard, nodular, and somewhat painful, and there was a sinus extending from the side to the head of the organ. A similar condition, although less advanced, was present on the right side. Scrapings from the sinus were examined, with negative results. On June 7th the man was operated on by Dr. Alexander, as follows: An incision about three inches long was made on the left side of the scrotum, passing close to the sinus. Another short incision was made on the opposite side of the sinus, joining with the first, thus isolating the opening of the sinus. The tissues were then cut through until the testicle was exposed. The sinus was dissected up to the epididymis, and then the epididymis, with the sinus, was cut away close to the testis. The tunica albuginea was stitched with catgut at the site of the incision, and the divided margins of the tunica vaginalis testis were brought together over the testicle, and the stump stitched to the lower end of the cord. The right side was treated in a similar manner. On each side the testicle was inverted and stitched to the cord with fine catgut sutures. The patient was discharged during the first week in July, cured. Tubercle bacilli were found in the tissues removed.

Tubercular Epididymitis.—Dr. Alexander also reported the following case:

Male; mulatto; aged twenty-three years. Admitted to the hospital on May 22, 1894. He stated that three years previous to his admission he had had gonorrhœa, and during that time one of his testicles became swollen. Two years later he had another attack of gonorrhœa, and both his testicles were swollen, and a sinus formed on both sides. When he came under Dr.

Alexander's observation these sinuses still persisted, both epididymes were hard, and the cord on one side was nodular. There was a moderate cystitis. This patient was operated on May 24, 1894, both epididymes being removed in the manner above described. The wound closed promptly, although on the left side the vas deferens had been taken away as high up as the internal ring. When the patient was last seen, in October, 1895, he was perfectly well.

DR. ALEXANDER also reported a case in which the testis on one side was affected with tuberculosis, while the opposite one was atrophied. In connection with his cases, the speaker exhibited a number of specimens.

DR. F. TILDEN BROWN said the removal of the epididymis in these tubercular cases, leaving the cord intact, is a rather unusual method of procedure. The general condition of the patient shown by Dr. Alexander is certainly remarkably satisfactory at the present time. It would be interesting to know whether the prostate and seminal vesicles had been involved or have since been invaded by an ascending process along the cord. The speaker asked what Dr. Alexander's object was in inverting the testis.

DR. ALEXANDER replied that he inverted the testis and stitched it to the cord in order to give it a better support. Neither the seminal vesicles nor the prostate was involved by the tubercular process in the first case. In the second case reported there was undoubtedly disease of the prostate; the urine was distinctly purulent, and has remained so.

Case for Diagnosis.—DR. C. L. GIBSON presented a patient with the following history:

Male; aged fifty-nine years; previous history unimportant, excepting that he had an inguinal adenitis some years ago. About three months ago he was injured, his testicles being severely squeezed. This was followed by an acute inflammation of the organs, which passed off in about six weeks. At the present time he has on the right side a typical tubercular epididymitis. On the opposite side the physical signs would indicate a syphilitic orchitis; the testis is enlarged, dense, and there is an entire absence of testicular feel. It does not resemble a tubercular process. The man gives no history of syphilis, nor has he thus far received any specific treatment.

DR. BROWN said he was inclined to think that both the testes in this case were affected with tuberculosis.

DR. RAMON GUITERAS said he agreed with Dr. Brown.

DR. ALEXANDER said he thought both testicles were tubercular. On the left side the diagnosis is obscured by fluid in the cavity of the tunica vaginalis.

DR. G. E. BREWER said he agreed with Dr. Alexander. A very similar case recently came under his observation.

DR. W. K. OTIS said he agreed with the previous speakers, that both testes were tubercular. The condition of the left testis in this case, however, he regarded as very infrequent. As a rule, we find the epididymis on the affected side more prominent than it is in this case. The fact that fluid is present strengthens the probability that it is tubercular; in those cases we are very apt to have fluid.

DR. JOHN VAN DER POEL expressed the opinion that in the case shown by Dr. Gibson both testes were tubercular.

Pyonephrosis due to Nephrolithiasis.*—Reported by Dr. Ramon Guiteras.

Dr. Eugene Fuller said that in cases like the one reported by Dr. Guiteras, where the condition of the opposite kidney is not positively known, it is better first to perform nephrotomy, and then, if necessary, nephrectomy. After prolonged drainage, the enlarged kidney collapses and is more easily removed. Furthermore, during this period we can study the character of the urine secreted by the opposite kidney, and if it is scant or of poor quality, or if there are any symptoms of uræmia, then it would not be advisable to perform nephrectomy at all.

Dr. Alexander said that when we take into consideration the condition of the kidney in Dr. Guiteras's case, he thought the latter was right in performing nephrectomy. A nephrotomy would have probably taken quite as long, and the patient would have been just as badly off afterward. The general rule of performing nephrotomy first and afterward nephrectomy, as suggested by Dr. Fuller, is a good one, but it can not be applied to all cases. As regards the treatment for acute suppression, the speaker said he preferred to use hot applications and mild diuretics rather than hot baths and hydrocathartics.

Dr. Fuller said that when he made his remarks he had not had an opportunity of examining the specimen in Dr. Guiteras's case. Since doing so, he thought the latter was perfectly justified in performing an immediate nephrectomy. The size of the stone was so enormous that it would have been almost impossible to remove it without removing the kidney itself.

Dr. Van der Poel referred to a case recently operated on by Dr. McBurney, where nephrectomy was performed for tuberculosis of the kidney. The opposite kidney and ureter were supposed to be in a normal condition. After the operation, the patient passed four ounces of urine and remained well for seven days; then symptoms of uræmic poisoning set in, and she died on the twelfth day. At the post-mortem, the remaining kidney was found to be in a condition of complete cystic degeneration, and the ureter was absolutely occluded by a fibrous cord.

Dr. Otis referred to the ease with which the ureters can be catheterized, especially in the female, and by this procedure we can always tell what condition the kidney is in. Catheterization of the ureters does not in any way interfere with the suggestion made by Dr. Fuller, of doing a nephrotomy primarily. In Dr. Guiteras's case, the speaker thought nephrectomy was indicated.

Dr. Brown said that, in view of the fact that death followed from suppression in Dr. Guiteras's case, it would perhaps have been better had a nephrotomy been performed, as suggested by Dr. Fuller, removing the stone either entirely or as much of it as possible, without producing severe laceration, then plugging the kidney with gauze. and thus hastening the operation. As regards the treatment for suppression, Dr. Brown said he was not inclined to agree with Dr. Alexander. Although his experience in this connection had not been extensive, he was inclined to favor hot packs or steam baths, or hot poultices applied over the loins. He would administer pilocarpine in preference to digitalis. He would also resort to hot saline infusions.

Dr. Guiteras said that if he had known beforehand that his patient was

* See page 36.

going to die after the nephrectomy, he might possibly have performed a nephrotomy instead. As regards the treatment for suppression, some years ago several cases of this kind came under his observation, and, after trying almost everything in the Pharmacopœia, he came to the conclusion that nothing produced a quicker flow of urine than the sweet spirits of niter. For this reason he expected good results from it in this case. Cupping he regarded as superior to any other local measures. The digitalis and strychnine were given forty-eight hours after the operation. The patient was then probably too weak for the wet pack, or for the administration of pilocarpine or hydrocathartics. Stimulants were indicated.

DR. ALEXANDER said he did not see how any one who had examined this specimen could suggest that the proper course in this case would have been a nephrotomy. On account of the size of the stone it would have been impossible to remove it in as short a period of time as it would take to remove the kidney itself. The calculus extended from the parenchyma to the pelvis and had numerous branches.

The Perfected Metro-urethrotome and some Other Instruments.*—DR. F. TILDEN BROWN read a paper with this title, describing and exhibiting a number of instruments he had devised. Among these were the metro-urethrotome, which was first described by him in the *New York Medical Journal*, February 12, 1887, and has since been perfected in various ways; the perineal tube-holder; an electric head-light for illuminating the urethra; several whalebone guides of small caliber; a perforated rubber disk to keep the soft rubber catheter in place; a catheter fender against which the return fluid strikes in irrigating the bladder or urethra, and a probe-pointed grooved catheter for facilitating external urethrotomy.

Correspondence.

THE REGULATION OF PROSTITUTION.

Editor of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

SIR: The following abstract of a report presented before the Academy of Medicine of Paris by Dr. Commenge will, I trust, be of interest to practitioners in general, and furnish conclusive proof of the value of regulating prostitution.

Under the title Venereal Diseases in the British and French Armies,† Dr. Commenge states that in June, 1894, the British Minister of War was questioned as to the development of syphilitic troubles in the armies of the metropolis and the colonies. The result of the investigations showed the situation to be very serious, proving that during the year 1892, out of 194,336 soldiers, 52,155 were admitted to hospitals suffering from venereal diseases—that is, over one fourth of the total number.

Comparing the number of men afflicted with *venereal diseases* in the

* Will be published in this JOURNAL.

† *La France méd.*, May 24, 1895.

British army with that of the French, the following results were obtained: The highest ratio of the French army was reached in 1875—viz., 74·9 in 1,000; in the British army it was 139·4 for the same year. The highest percentage for the British army was in 1885—viz., 274·4 in 1,000; in the French army it was only 52·1 for the same year. The highest number of *syphilitic* cases in the French army was in 1875—viz., 11·3 in 1,000; in the British army it was 28·8. The highest proportion in the British army was reached in 1887—viz., 46·6 in 1,000, whereas it was 8·9 in the French—that is, only one fifth of the number during the same year.

Dr. Commenge made analogous investigations in order to determine the proportion of soldiers afflicted with venereal diseases in the Russian army, and the following tables, comparing the ratio in the armies of the three different countries, give the results obtained:

	Great Britain.	France.	Russia.
	Per cent.	Per cent.	Per cent.
1889	217·0	45·8	40·7
1890	212·4	43·8	43·0
1891	197·4	43·7	41·5
1892	201·1	44·0	44·6

The proportion of soldiers afflicted with syphilis during the same period was:

	Great Britain.	France.	Russia.
	Per cent.	Per cent.	Per cent.
1889	35·7	9·1	12·9
1890	37·3	9·1	13·4
1891	32·2	8·9	12·2
1892	33·8	9·2	13·7

Continuing his investigations, especially in reference to the French army, Dr. Commenge shows that the different army divisions were more or less infected with venereal diseases according to whether they were stationed in localities where clandestine prostitution existed or where prostitution was regulated. From his investigations Dr. Commenge draws the following conclusions:

(1) Venereal diseases are of far more frequent occurrence in countries where prostitution is free than in those in which it is regulated; (2) the regulation of prostitution tends to check the development and spreading of venereal diseases; (3) the results obtained by the foregoing investigations are in harmony with the resolutions passed by the Academy of Medicine in 1888, which called the attention of the authorities to the danger of prostitution, and the measures to be adopted to protect public health.

The foregoing figures speak for themselves, and it would be superfluous to discuss them. Would it not be advisable for us, in our metropolis, to follow the example of the French, since so much good may be gained thereby? Would it not be better to recognize prostitution as a necessary evil—for it will exist in spite of all suppression by the authorities, moral preaching from pulpits, etc.—and have it regulated by competent men? Surely, the evils to

public health arising from prostitution might be alleviated, in a great measure, if the prostitutes were kept under medical control, and examined at regular intervals, as, for instance, in Paris and Vienna. This would, at least, be putting the whole question on a more scientific basis. And it would certainly seem more becoming and expedient, as well as effective, in combating the pernicious consequences, for a medical man to start a crusade against prostitution than one of another profession, as has unfortunately been the case in the city hitherto.

R. K. MACALESTER, M. D.

October 12, 1895.

RUBBER SHEET IN URETHRAL AND VESICAL IRRIGATION.

Editor JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

DEAR SIR: I herewith send you a photograph illustrating a rubber sheet I have been using both in my dispensary and private practice, and one which gives me entire satisfaction. It is a piece of ordinary rubber sheeting, thirty-



six inches by thirty-six inches. Eighteen inches from one end, cut out a circular piece two inches in diameter; have it bound to prevent tearing.

The method of using the sheet is as follows: When giving your patient any urethral or vesical irrigations, you instruct him to lie down on your

table, pull his trousers and drawers down to his knees, throw the sheet over him, draw the penis through the hole, and depress that portion lying over the triangle formed by the stretched trousers as the base, thighs as sides, penis and perinæum as apex. After giving the irrigation, the fluid which has been used lies in the depressed portion of the sheet, and can be readily lifted up with the sheet and deposited in a vessel. I have been using the white rubber sheeting, but should prefer the black, as by the use of solutions containing silver nitrate the sheet becomes stained, and conveys the idea to the minds of your patients that you are not sufficiently careful in the ablution of your instruments.

Yours truly,

W. W. Townsend,

Rutland, Vt., October 20, 1895.

Book Reviews.

International Atlas of Rare Skin Diseases. Edited by P. G. Unna, Malcolm Morris, H. Leloir, and L. A. Duhring. Parts XI and XII. Hamburg und Leipzig: Leopold Voss.

The illustrations in Parts XI and XII exhibit the same degree of artistic excellence which has called forth favorable comment in our previous notices of this Atlas.

Plate XXXII, by P. J. Thompson, is entitled *Mycosis Fungoides?* An interrogation mark is, we think, properly affixed to this title. Neither in its objective characters nor in its clinical course does it correspond to the classic description of mycosis fungoides. Its occurrence at an early age and its prompt cure under a purely local treatment further serve to differentiate it.

The subject was a girl aged fourteen years. The lesions, few in number were limited to the lower part of the back, just above the buttocks, and a few raised spots on the right thigh. In the lumbar region the lesions are described as presenting a peculiar appearance, "as if an enormous butterfly had alighted on the patient's back with its dark-blue wings covered with silvery scales widely expanded." "The shape of the two large lumbar plaques is very irregular, but with a perfectly circinate outline. The larger one on the left side measures thirteen centimetres in its longest diameter, the right one nine and a half. They both appear to be made up of a number of small, coalescing patches. They project about half a centimetre above the level of the surrounding skin, from which they seem to rise abruptly, without any erythematous or inflammatory zone. The patches are of a dark, slaty-blue color, covered with thick, silvery-white scales. The left one is slightly excoriated, and gives issue to a little serous oozing. Patient otherwise in the best of health."

The morbid anatomy and bacteriological investigation showed nothing conclusive.

Plate XXXIII, by Petrini de Galaty, represents *Lupus Tuberculeux et Syphilides cutanées à petites Papules.* The chief interest in this case is the coincidence of cutaneous tuberculosis and syphilis. While what has been termed scrofulo-syphilis is by no means uncommon, there does not seem

to be here a combination or symbiosis of the two morbid processes, but each disease is clearly defined with distinct and typical features. The patient was twenty-two years old. Upon the right side of the face, involving the side of the nose, the upper and lower lips, the chin and inferior region of the cheek, there is a typical picture of lupus vulgaris. Along the side of the neck, extending from the ear to below the angle of the jaw, there is a chain of scrofulous gummata, some of them ulcerated. The submaxillary glands on the left side are also swollen. The presence of Koch's bacillus was demonstrated in the secretion of the ulcerated gummata. Other lesions of a lupous nature were found on the lower limbs. Evidences of the disease have existed since childhood.

Three months previously the patient had acquired a syphilitic chancre, and when he first came under observation his body was covered with a characteristic miliary papular syphilide, with mucous patches on the tonsils and the anterior pillars of the palate.

Plate XXXIV, by Albert G. Francis, is entitled *Angioma Seriginosum*. The patient, a girl aged four years, had been under observation since she was four months old. At birth a port-wine mark was noticed on the plantar surface of the right heel. Within a few weeks similar nævi appeared on the perineal surface of the right leg, and later still on the outer side of the right buttock. The picture shows a linear distribution of port-wine marks extending from the trochanter major along the outer surface of the limb to the sole of the foot, broken in the lower part of the thigh and upper third of the leg by normal skin. The larger patches seem to be formed by the confluence of smaller ones into more or less concentric or stellate shapes, with outlying satellites.

While this case differs in its appearance and mode of development from the cases first described by Hutchinson as infective angioma or nerve lupus, in which there is a tendency to form circles, rings, and gyrate lines by clearing in the center while spreading peripherically, the author is disposed to regard it as belonging to a subgroup of the hæmangiomata. In presenting the literature of the subject, no reference is made to the extremely typical case of Dr. James C. White, published in this Journal.

Plate XXXV, by Louis A. Duhring, is entitled *Neuroma cutis dolorosum*. As, according to the author, this is the only case of the kind described in this country, only one similar case having been recorded in Europe, the propriety of classing it among rare skin diseases can not be questioned.

In this case the disease consisted of numerous split-pea sized and shaped elevated but flattened tubercles occupying the left scapular region, shoulder, and anterior surface of the upper arm. In the main central patch, over the left shoulder, the lesions were confluent; elsewhere they were discrete. They were firmly fixed in the skin, hard and solid to the feel. The general surface of the eruption was rough, and the skin slightly scaly.

The most notable symptom was an excruciating pain, more or less paroxysmal in character, and recurring several times during the day and night. The tubercles were most exquisitely sensitive, slight pressure or mere contact with the clothing causing great suffering. Exsection of the brachial plexus of nerves of the affected side was followed by temporary relief, but within a few months the pain returned; in a year it was as severe as before the opera-

tion. Microscopical examination of sections of the excised growth showed the structure to be that of a typical amylinic neuroma.

In Plates XXXVI and XXXVII, by Julius Heller, are represented several examples of *streaked skin affections* of the *lower extremity*. It will be observed that this constitutes a new departure in the preparation of the plates of this atlas. Instead of each plate being the contribution of a single author, Dr. Heller has collected from various authors a number of cases—some old, others recent—of this particular class of skin affections. This plan has much to commend it. In these plates the author has placed Unna and Phillipson's two cases of *ichthyosis cornea* (hystrix) *partialis*, Shearar's case of *eczema following the course of the small sciatic and short saphneous nerves*, and Neumann's of *nævus papillaris neuroticus* in juxtaposition with his own. It is thus seen that, while these cases have distinctive anatomical and clinical features in common, they are differentiated by certain peculiarities which the authors refer to differences in their pathogenetic mode. Shearar and Neumann assume in their cases a relationship between the disease and the superficial or deeper nerves; Phillipson and Unna explain the distribution of the eruption by means of Voigt's boundary lines, while Heller has demonstrated that in his case it depends upon the lymphatics.

Cutaneous Medicine. Louis A. Duhring. Part I. Anatomy, Physiology, Symptomatology, Etiology, Pathology, Diagnosis, Treatment, Prognosis. Philadelphia: J. B. Lippincott Company, 1895.

This is the book on which Americans can most surely found their claims to a place in the front ranks of the advance in the field of later dermatology. Unless indications fail and the standard of excellence is not maintained, the work, if the reader will excuse a trite phrase, is an epoch-maker and will displace the treatises now in use as a standard. It can hardly fail of translation into the tongues which have honored its predecessor from the same pen, or of acceptance everywhere save in Vienna. It betrays none of the prejudices of Kaposi, is as rich in reference as Besnier-Doyon, without prolixity and with the advantage of better arrangement, it is fuller than Crocker, and it is uniform as the result of one man's thought and long experience, not a compilation of the work of a number of men with widely divergent views.

The title is a striking one, emphasizing as it does the author's reiteration that dermatology is not a thing apart but a province, and a wide one, of general medicine. The keynote of the work, however, lies in a single sentence in the preface. "The work, as a whole, rests on clinical observation supported by pathology and pathological anatomy." That alone is enough to bring joy to the hearts of many here in which the charge of empiricism, too often well based, has long rankled. It contains much that we have never seen in volumes on dermatology, but nothing that is not of vital importance to the subject and little to which exception can be taken. This treatise is not dedicated to students—theirs is no part in its use. It is a reference and guide for those who have already some interest in and knowledge of this division of medicine.

The text presents a good appearance. The type is clear and the pages are not broken for the insertion of cuts—a marked improvement. The illustrations, all of them anatomical in this part, are carefully selected from the best histologists—Unna, Ranvier, Piersol, Koelliker, etc.—and can hardly be im-

proved upon. The references are very numerous, placed at the foot of each page, showing a gratifying absence of "*loc. cit.*" They are gathered from every source.

In order that the praise which is due may not appear fulsome (always a poor compliment), some of the points noted in a careful reading may be mentioned. On page 10 the statement is made that elastic fibers are scanty or entirely wanting (in the papillæ). This is a strange mistake for one so thoroughly familiar with Unna's work. His orcein method demonstrates most beautifully arches of elastic fibers in the papillæ, with fibrils running close to the basement membrane (well shown in sections prepared by Dr. G. T. Elliot). Page 26 contains the statement that "at birth the colored races are comparatively unpigmented," and the next sentence declares that Morison found pigment in a negro one month before birth, leaving the reader in doubt. The ambiguity, at least, should be removed. Men, the writer among them, have delivered children at seven months as black as a coal. Heitzmann's fibrillated protoplasm finds a place in the teachings of few histologists at the present time; the question, in any case, is hardly one for discussion in a work on dermatology. The author divides the epidermis into stratum corneum and stratum mucosum, a better name than rete, drawing the line between the granular and clear layers. He states (quoting Koelliker, page 37) that the columnar epithelium of the coil glands is seated directly upon a layer of unstriped muscle without intervening membrana propria. It is not always difficult to demonstrate the latter, and an epithelium without a basement membrane would be an anomaly. Occasionally the anatomy is drawn out to a very fine point, as in the case of the hair. There is nothing to be gained in the change from the older terms, which are applicable and thoroughly understood, to Unna's new ones. "Epidermis" and "root-sheath proper" will not displace outer and inner root-sheath, especially as both structures are epidermic; the layers of Henle and Huxley, if objectionable on the ground of the proper names, convey to the histologist a definite meaning, and are certainly more convenient than outer and inner layers of the root-sheath proper. On the other hand, the structure of the hair itself is treated most satisfactorily. The separation of the cuticles of the inner root-sheath and of the hair is an histological refinement which will appeal to many.

Passing to the division of Physiology, a warning which might well be heeded among the profession as well as laity is given regarding the Turkish bath—that it is not applicable in cases of circulatory disturbance. The author adds the weight of his opinion to Unna's side in the controversy recently reopened regarding the secretion of fat by the sweat glands, that "the sweat glands as a whole secrete fat, and besides that, at other times, a watery secretion without fat" (Henle). The author includes among the primary lesions tumors, a division which he claims is of use clinically, although recognizing the vagueness of the term. He uses too the word tubercle, and makes no mention of nodule, introduced by Crocker and undoubtedly preferable. Included in the division of symptomatology is a sketch of the nerve supply to the skin convenient for reference.

Under Ætiology, the author declares his belief in diathesis, defined as a persisting morbid proclivity, and in heredity as regards certain diseases—e. g., eczema and psoriasis—with the corollary, however, that they more often develop in the individual primarily than by inheritance. Internal causes

receive lengthy discussion, a wise provision in these days of the advocacy of external treatment alone. Many observers will decline to admit the views advanced as to structural changes in the skin from maternal impression, in spite of the evidence adduced. Among external causes there is a warning for the man who insists on his three hundred and sixty-five baths per annum. Hand-shaking and kissing he condemns utterly.

The chapter on Pathology is a long one, and worth the reading. Hyperæmia and œdema are separated from inflammation, since the only essential cause of the latter is invasion by pus organisms. Among parasites are considered protozoa and sporozoa. Duhring shares the view rapidly gaining ground, that the so-called organisms in psorospermosis and Paget's disease are probably not parasites, but cell inclusions and abnormities. He gives four cases of veritable disease with sporozoa, which Gilchrist investigated, and which bear no resemblance to Darier's disease. Welch thinks many of these bodies are yeast fungi, and the author concurs with him. Duhring thinks that too little stress is often laid on the history of the case, especially the hints derived from statements as to previous therapeusis.

In speaking of Treatment, the indications for each drug and its effect on the skin are given. Arsenic, for example, is properly limited to the stage of disease in which active cell proliferation has ceased. Modes of treatment, thoroughly modern, come next. It is a matter of some surprise that from the list, which is practically complete, Unna's casein ointment, an elegant preparation in many respects, should be omitted, since it has been in use for a year. Some doubt seems to lurk in the author's mind as to the efficacy of Lassar's, and he gives a line only to Elliot's bassorin paste. He thinks plaster-mulls more efficacious than salves spread on muslin. The page of General Prognosis is rather unsatisfactory, but it is true that "there is little to be said regarding the prognosis of cutaneous diseases as a class."

In the name of American dermatology we ask, even demand, that the work be continued to completion, having a right vested in the pride we take in it. We hear that the number of parts is still uncertain, and may reach ten or twelve. The price ($2.50 per part) is not small, but the difference lies in its worth. J. C. J.

The Histopathology of Skin Diseases.—Mr. William F. Clay, of Edinburgh, will publish shortly the authorized English edition of *The Histopathology of the Diseases of the Skin*, by Dr. Unna, of Hamburg; translated by Dr. Norman Walker, assistant physician in Dermatology in the Royal Infirmary, Edinburgh.

This new edition will be revised with additions by the author, and forty four additional illustrations in the text specially drawn for this edition, hitherto unpublished, now rendering Dr. Unna's important work accessible in England to the American profession.

Therapeutic Notes.

Serum Injections in Secondary Syphilis (*Semaine médicale*, xv, p. 186, 1895).—Viévorovsky treated five patients in this stage with subcutaneous injections of serum obtained from the blood of robust persons suffering from tertiary disease. The serum was filtered and 0·5 per cent. of carbolic acid added to it. The quantity injected varied from four to twenty cubic centimetres, the number of injections, given usually in the scapular region, averaging twenty-one to twenty-three for each case. No other treatment was used, and the author states that the general condition improved rapidly; healing of the initial lesion and disappearance of the eruption were hastened. Mucous patches were most rebellious to treatment, and the relapses which occurred yielded less readily than the early symptoms.

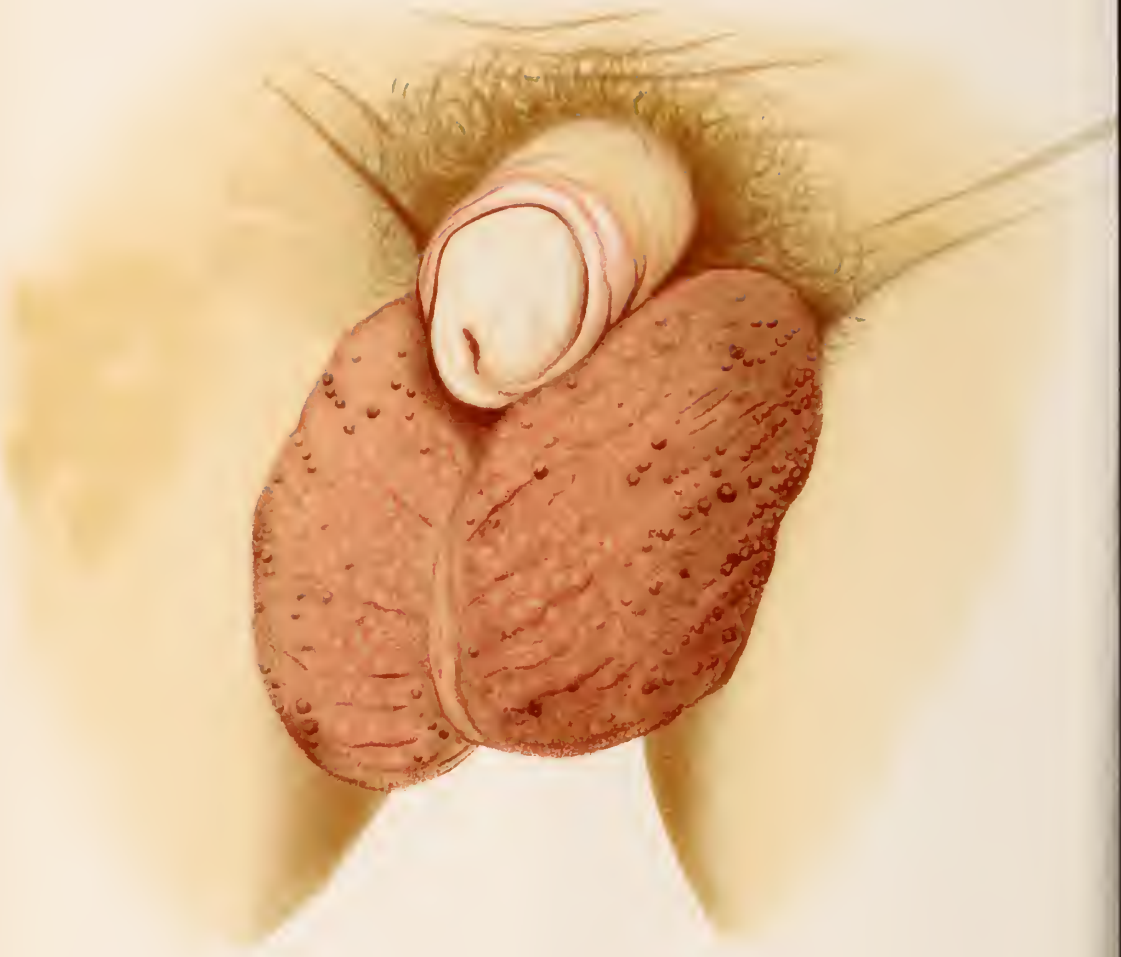
Creosote in Lupus (*Semaine médicale*, xv, p. 198, 1895).—Zérénine uses the beechwood product, pure, in compresses, or a ten to thirty per cent. solution in oil or glycerin, with good results. The treatment is slow, but is useful when operative measures are declined, and produces a minimum of scarring.

Chromic Acid combined with Nitrate of Silver in Syphilis and other Affections (*Monatshft. f. prakt. Derm.*, xxi, p. 81, 1895).—Boeck applies to the lesion to be treated a ten-per-cent. solution of chromic acid, and immediately following it the solid stick. Chromate of silver and free nitric acid are formed, the latter acting vigorously on the tissues, but with less pain than when it alone is used. The combination is particularly efficacious against indurated syphilides of the mouth and dry papules of the mucous membranes anywhere, but is serviceable in chancroid, nævus, lupus erythematosus, and condylomata. A crust is formed by the caustic, which falls off in a few days.

Thyroid in Lupus (*Brit. Jour. of Derm.*, vol. vii, No. 12, p. 393).—Malcolm Morris presented to the London Dermatological Society a case of lupus of long standing which had caused extensive destruction of nose, cheeks, and neck. Under thyroid, one to five tabloids daily, the ulcers healed, and the disease progressed satisfactorily.

Alopecia Areata in Children (*Rev. intern. de. méd. et de chir. prat.*, September, 1894).—Feulard uses an ointment at night composed of salicylic acid, 15 grains; precipitated sulphur, 45 grains, to 225 grains each of lard and vaselin; washes the head with salicylic soap in the morning, and applies a lotion of corrosive sublimate, 0·5 grain, alcohol and tincture of rosemary, each 3·5 ounces. Once a week he brushes on equal parts of essence of wintergreen and ether.

Ichthyol in Burns.—This drug is being extensively employed in the treatment of burns of the first and second degree, and is most efficacious in alleviating pain, reducing œdema, and promoting healing. It is used dry, diluted with zinc oxide or bismuth, the powder spread evenly over the surface, in ointment (ten to thirty per cent), or in combination of the two methods.



JOURNAL OF
CUTANEOUS AND GENITO-URINARY
DISEASES.

VOL. XIV. MARCH, 1896. No. 3.

Original Communications.

ANGIOKERATOMA OF THE SCROTUM. RAYNAUD'S DISEASE OF THE EARS. LUPUS ERYTHEMATOSUS DISSEMINATUS DISAPPEARING DURING PREGNANCY.*

BY J. A. FORDYCE, M. D.,

Professor of Dermatology and Syphilology, Bellevue Hospital Medical College; Visiting Dermatologist to the City Hospital, etc.

THE patient, a male aged sixty, was admitted to the City Hospital in the spring of 1894 for some urinary trouble. He was somewhat feeble both mentally and physically, and could give little information regarding the eruption which was present on his scrotum, except to say that he had had it for a number of years.

He feared that some harm would come to him if he remained in the hospital, and demanded his discharge before a careful study could be made of the interesting skin lesions which he presented.

An opportunity was afforded, however, of excising a number of the small tumors for microscopic purposes, and of having made the colored sketch, which is reproduced in connection with the present article.

The skin covering the thighs and lower part of the abdomen was the seat of a number of patches of vitiligo. The patient was also affected with a double varicocele, which is interesting in connection with the superficial vascular dilatation. His hands and feet were free from any skin affection, and he denied having suffered with chilblains. The scrotum, especially on its lateral and posterior surfaces, was the seat of a great number of small, spherical-shaped, dark purple tumors (see colored plate). They were arranged in a linear manner as if following

* Read at the nineteenth annual meeting of the American Dermatological Association, Montreal, Canada, September, 1895.

the superficial vascular supply of the parts. The small growths were from a pin's head to several times that size, their dimensions being pretty uniform. Pressure caused the color of the majority of the tumors to disappear. In some of them, however, the color was only partially lost.

The small growths were distinctly elevated above the surface of the scrotum, seeming to rest on it rather than to be imbedded in the skin. Some of them were covered by a slightly thickened horny layer, under which minute dark-red points could be seen, which gave the tumors a wartylike appearance.

Composite lesions were formed by the union of two or more of the smaller ones, which, however, preserved all the characteristics of the original growths. No pain, pruritus, or other subjective sensations were complained of by the patient. Puncture of the tumors with a needle was followed by slight hemorrhage.

In the cases heretofore reported the eruption has been, with few exceptions, confined to the extremities.

Dr. Zeisler's case * presented, in addition to characteristic lesions on the hands and feet, nævuslike patches and pedunculated vascular tumors on the forearms, over the patellæ, the legs, thighs, and auricles.

It is probable that the same pathological condition produced the vascular dilatation in these various localities, the hypertrophy of the epidermis covering the lesions on the extremities being favored by the anatomical condition of the parts and exposed position of the vascular tumors.

The presence of patches of vitiligo in Dr. Zeisler's case and my own, while probably a coincidence only, is yet worthy of notice. In most of the cases reported chilblains preceded the appearance of the angiomatous tumors, and the damaged state of the blood-vessels is looked upon as a strong predisposing factor to their development; the localization of the affection on the hands and feet is therefore readily explained.

The unusual site of the affection on the scrotum in my case demands a careful study of the histological appearances, and a comparison with the minute structure of the cases which have occurred in typical localities. The usual ætiological factor, chilblains, can not, of course, be invoked to explain the occurrence of the localized vascular tumors on the scrotum. The tendency to dilatation of the blood-vessels as manifested by the double varicocele, and the degenerative state

* *Transactions of the American Dermatological Association*, Seventeenth Annual Meeting, 1893.

of the vessels and surrounding connective tissue incident to old age, were probably the most potent causes in bringing about the condition in question.

The dilatation of the capillary vessels is looked upon by all who have studied the affection as the primary and essential condition, the change in the epidermis being of a secondary nature.

If we adopt this view, which is doubtless the true one, any dilatation of the papillary loops should in time be followed by thickening of the epidermis and the other anatomical changes which are found in this affection.

Mibelli * gave the first anatomical description of the condition found in this affection, and proposed the name "angiokeratoma" for the disease. The lesions which formed the basis of his observation occurred on the dorsal surface of the fingers of a fourteen-year-old girl and had existed for several years. They were preceded by chilblains.

The stratum corneum was so much thickened in this case that the gross appearances of many of the lesions suggested the diagnosis of keratoma. The name proposed by Mibelli is a very appropriate one, as it accurately indicates the pathological condition which exists.

Before Mibelli's careful investigation, cases of the same affection had been noted by other writers under various names; the true character of the lesions had not, however, been determined.

Cottle † seems to have made the first observation regarding the disease. Crocker ‡ refers to a case which he described in the first edition of his text-book under the heading of Verruca, a further history of which he gives in the *British Journal of Dermatology* for 1891.

Colcott Fox # described a number of cases of the disease in 1886 and in 1889; in the latter year, under the name of Cases of Lymphangiectasis of the Hands and Feet in Children. Since the publication of Mibelli and Pringle's articles he admits the inaccuracy of his observation regarding the histology of the lesions, and agrees fully with these investigators regarding the morbid changes and the name proposed. Dubreuilh ‖ described the disease under the title of Telangiectatic Wart. This case is in every way a typical one, the patient affected being a young girl who had previously suffered with chilblains.

* *Giornale italiano delle mal. ven. e della pelle.* Fasc. iii, September, 1889. *Internat. Atlas of Rare Skin Diseases*, No. II, 1889.

† *St. George's Hospital Reports*, vol. ix, 1877–'78, p. 758. Quoted by Crocker.

‡ *Diseases of the Skin*, second edition, 1893.

These cases are referred to at length in Pringle's article on Angiokeratoma, *British Journal of Dermatology*, 1891.

‖ *Annales de la Polyclinique de Bordeaux*, 1889.

We are indebted to Pringle's* article for a most accurate and painstaking description of the clinical appearances and morbid anatomy of the affection, as well as for an analysis of most of the cases which had been met with up to the time of its publication.

Pringle reported two cases affecting girls with chilblains, and his histological description agrees in all essential points with that previously made by Mibelli.

Since the publication of this article cases have been reported by Audry and Deydier,† Brocq,‡ Thibierge,# Joseph,‖ Tommasoli,△ Renault,◊ and others, in addition to which several instances of the disease have been observed but not published.

Histology.—For microscopic study a number of tumors of various sizes were excised from the scrotum, hardened in absolute alcohol, and stained with different coloring agents.

A section through two small tumors situated side by side is shown under a low power in Fig. 1 (plate).

Two cavernous spaces containing blood are seen directly beneath the epidermis, divided by irregular septa and bounded on all sides, with the exception of the low portion of one of them, by epidermic cells.

Directly above the lacunar dilatation the rete layer is thinned as if from pressure of the distending cavity, while the stratum corneum is shown somewhat hypertrophied. At the lateral margins the rete mucosum is considerably hypertrophied, which is more evident in Fig. 2 (plate), representing a single tumor entirely surrounded by the proliferated rete layer.

At the right of the blood cavity the thickened rete is well shown.

The cavernous spaces are filled with red and white blood-corpuscles in normal proportions, and under a low power their lining membrane seems to be made up of epithelial cells.

With high amplification, however, they are found to be lined with a greatly distended connective-tissue layer which separates the blood from the epidermis. In certain sections blood spaces are found to exist in the epidermis, surrounded only by disintegrated epithelium, as if the blood had penetrated between the cells and produced the cavities in

* *British Journal of Dermatology*, 1891.

† *Lyon méd.*, 1892. *Ann. de dermat. et de syph.*, 1893, p. 381.

‡ *Ann. de dermat. et de syph.*, 1892, p. 819.

Ann. de dermat. et de syph., 1892, p. 1139.

‖ *Berl. klin. Woch.*, 1892, p. 493. *Dermat. Zeitschrift*, 1894, p. 16.

△ *Commentario clinico delle malattie cutanee e genito-urinarie*, 1893.

◊ *Ann. de dermat. et de syph.*, 1894, p. 1248.

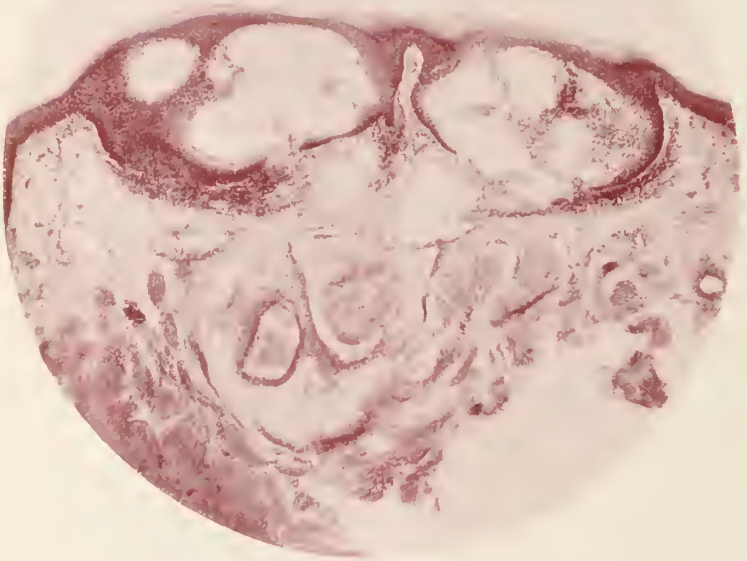


FIG. 1.—Section through two adjacent tumors.
Spencer 1 in. *Zeiss* projection ocular 2. × 50.

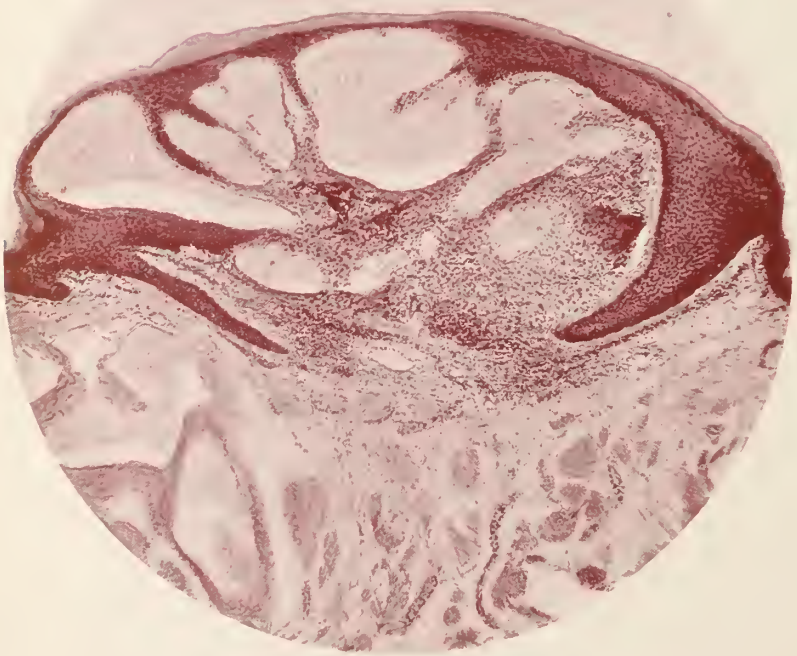


FIG. 3.—Section through larger tumor, showing papillary vascular dilatation and hypertrophy of the rete Malpighii.
Spencer 1 in. *Zeiss* projection ocular 2. × 50.



FIG. 2.—Section through small tumor completely inclosed by the hypertrophied rete Malpighii.

Spencer 1 in. Ocular 1¼ in. × 60.

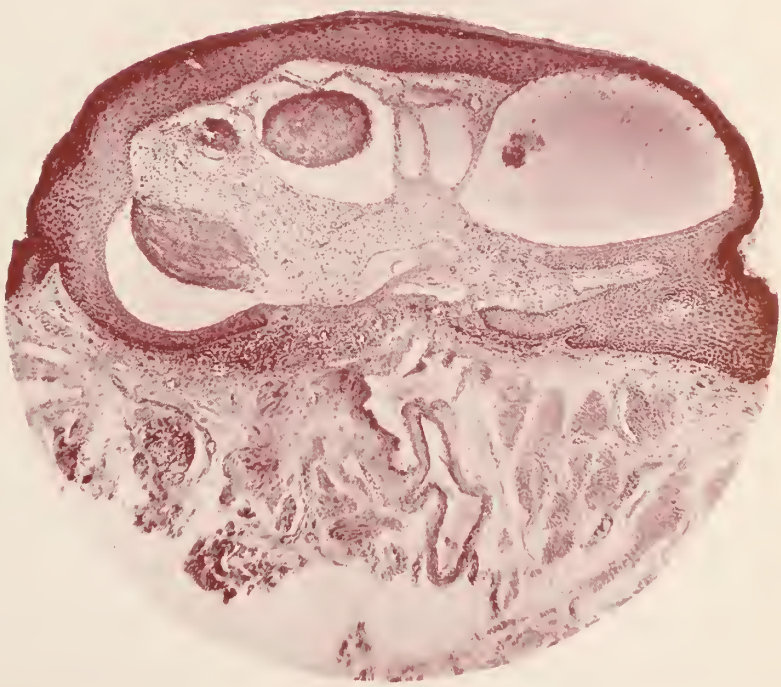


FIG. 4.—Section through larger tumor, showing cavernous spaces divided by septa, and containing organized blood clots.

Spencer 1 in. Ocular 1¼. × 75.

question by a destructive action on the epidermis rather than by stimulating the growth of the rete layer, as seems to be the case in the formation of most of the cavernous spaces.

Beneath the lower margin of the proliferated rete a round-celled infiltration is present, which is distinctly shown in Figs. 1, 2, and 3 (plate).

Blood pigment is intermingled with the cell infiltration, and there is some indication of fibroid-tissue formation about some of the subpapillary blood-vessels. There is also to be observed in this area a considerable vascular dilatation of the same character as shown in the papillary region (Figs. 3 and 4, plate).

Figures 3 and 4 represent sections through larger tumors, the cavernous blood spaces being more distinctly shown, as is also the elevation of the tumors above the level of the skin.

The lower border of these tumors is not completely encircled by the hypertrophied and proliferating rete Malpighii, being formed by the subpapillary portion of the derma in which are seen greatly dilated blood spaces.

On the right of Fig. 4 a large cavernous space is seen to be filled with blood-corpuscles, which have by pressure caused a marked atrophy of the epidermis.

On the left of this section the circulation has been obliterated, as the lacunæ are occupied by concentric layers of fibrin containing blood-corpuscles and pigment.

Fig. 5 represents a more enlarged view of the cavernous spaces with their dividing septa. The stratum corneum is also shown to be considerably thickened.

An examination of the sections shows that the lesions consist of lacunar spaces filled with blood occupying the papillary portion of the derma, some of which are inclosed in the rete Malpighii. These cavernous spaces are evidently the essential feature of the disease, and are probably the primary pathological condition.

It is the opinion of Mibelli and Pringle that these lacunar dilatations result from changes in the papillary vessels, gradually brought about by repeated attacks of chilblains which impair the contractility of their walls and cause permanent telangiectases.

While in my case such a cause had not been present, it is not unreasonable to suppose that the tendency to vascular dilatation, and the impairment of the normal connective-tissue support to the vascular walls which was shown in a marked atrophy of the scrotal tissues, were the active agents in bringing about the condition described.

It is the opinion of both the gentlemen formerly quoted that the

primary pathological change is vascular and the altered appearance of the epidermis a secondary phenomenon.

My own sections would lead me to coincide in this view and also in Pringle's hypothesis that the blood spaces in the rete Malpighii are caused by a downgrowth of the cells of this layer, producing a constriction of the terminal loops and their resulting distention.

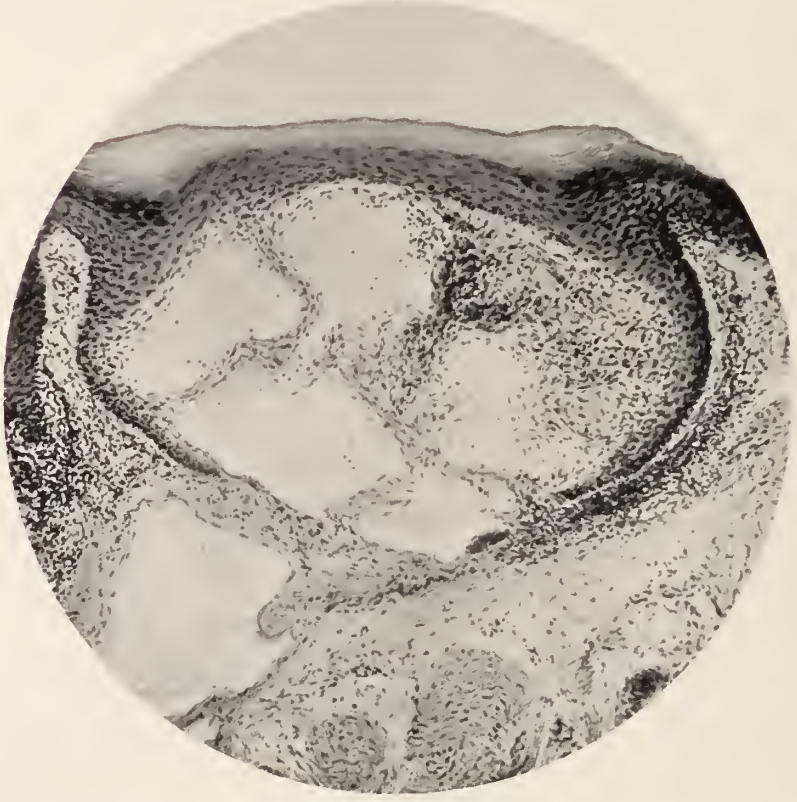


FIG. 5.—Spencer, half inch. Projection ocular 2, Zeiss. × 175. Cavernous space filled with blood corpuscles and divided by fibrous septa. Hypertrophy of the stratum corneum and rete Malpighii.

My case differs from those previously reported in the peculiar localization of the tumors, the absence of chilblains as a cause, and in the minor grade of keratosis.

When we compare the normal thickness of the horny layer over the hands with that on the scrotum, this discrepancy can readily be explained. In all the essential histological features, viz, the presence of blood spaces in the epidermis and papillary region, the prolifera-

tion of the rete Malpighii and in the presence of an inflammatory infiltration in the derma, it corresponds very closely with the classical cases reported by Mibelli and Pringle.

The tumors have been successfully treated by electrolytic puncture with the negative needle and by the galvano-cautery.

Raynaud's Disease of the Ears.

The patient, a male, aged thirty-nine, was first seen in March of the present year (1895.) His habits and family history are good. He is able to do physical work, and does not suffer with headaches. He describes a venereal sore eight years ago, which he states was followed by loss of hair, sore mouth, and sores on his legs. He also had some affection of the eyes after his venereal infection. Had gonorrhœa thirteen years ago, and again five years ago, both of which attacks were followed by rheumatism in the wrist and small joints of the fingers. He has never suffered in a marked degree with cold hands or feet.

His present trouble began in August, 1894, on a warm day. The ears at this time became cold and blue, and remained so for a period of several hours. They then gradually resumed their normal color.

Such attacks were frequent until January, 1895, when that portion of the auricle shown in the illustration assumed a permanent bluish-black color, which persisted up to the time he came under my observation in March of the present year. He states that the ears feel numb and cold, and that a burning pain is frequently present in them.

Present Condition.—The colored illustrations which I show will give a better idea of the symmetrical location of the affection than any description could accomplish. (Illustrations shown at the meeting.)

Both ears were distinctly cold, and of a purplish-blue color for some distance around the seat of the gangrene. The gangrenous area had formed at the junction of the upper and middle thirds of the auricle, and occupied a surface about half an inch in diameter (see cut).

It was bluish-black in color, dry, and without odor or suppuration. On scraping it, the diseased tissue could be readily removed, and appeared more like coagulated blood than like a sloughing mass. Little or no pain was produced by attempting to remove the dead tissue.

The purplish color extended for a considerable distance around the imperfect line of demarcation.

Both eyes showed the scars of an interstitial keratitis which the patient refers to the syphilis of eight years ago.

The patient was given no internal medicine; he was directed to use a simple ointment and report at the clinic within a week.

He was not seen again until August 30th, when no trace of the

disease was found except superficial cicatrices on the ears, the scar on the left side being more noticeable than on the right.

The interest of the case, aside from the somewhat unusual site of the gangrene, lies in the possible ætiological relationship of syphilis to



FIG. 6.—Raynaud's disease of the ears; showing the gangrenous areas.

the local disease. The interest of this case is strengthened by the observation recently made by an English surgeon, Mr. Wherry (*Clinical Sketches*, August, 1895), of the occurrence of Raynaud's disease of the fingers, toes, and ears in a fourteen-year-old boy, the subject of hereditary syphilis, who also presented the scars of an interstitial keratitis.

The implication of the arterial coats in both early and late syphilis, leading to lessened and obstructed blood supply, is doubtless responsible for many of the cases of Raynaud's disease in patients with syphilitic disease. When in addition to this obstructive endarteritis there is an added element of vascular spasm, due to cold or other causes, all the conditions necessary to bring about the localized gangrene are present.

It is not the intention of the writer to enter into a consideration of the ætiology of Raynaud's disease, which is doubtless the result of many conditions, and may be due in certain instances to a vascular spasm, pure and simple, brought about through disturbance of the central or peripheral vaso-motor apparatus.

Lupus Erythematosus Disseminatus disappearing during Pregnancy.

Mrs. F., aged twenty-five, married eight months. Six months pregnant. Has always enjoyed good health. No skin disease before the present one. She had an erythematous eruption on the face for some months before her marriage, which was attended by marked pruritus.

On the hands and arms the affection first appeared, two months after her marriage, at the beginning of her pregnancy.

Examination shows a general hyperæmia of the face, uniform in character, which is free from any evidence of atrophy, except at the margins of the erythema, below the ears, and on the neck. Even here the cicatricial depression is so slight as to escape notice, except on very careful examination.

There are no spots on the scalp, and none on the body, except those shown in the colored drawings. (Drawings shown at meeting.)

On the backs of the hands and forearms the eruption is symmetrical, showing distinct atrophy of the skin in the larger patches, and to a less extent in some of the smaller ones. The edges of the patches show very slight infiltration and no scaling. The entire process impresses one as a mild type of hyperæmia, which has resulted slight atrophy of the central parts of the lesions.

The patient was examined again shortly before these notes were taken, when almost at term. At this time all evidence of the disease had disappeared, except the atrophied spots, which were surrounded by a pigmented zone.

In this connection I recall the case of a woman in the South whose husband wrote me in regard to the treatment of his wife for a lupus erythematosus of the face. He stated that the eruption had entirely disappeared during a recent pregnancy, but had recurred in a form equally severe after her confinement.

A CASE OF RHINOSCLEROMA ORIGINATING IN THE UNITED STATES.

By GROVER WILLIAM WENDE, M. D.,
Clinical Instructor in the Diseases of the Skin, University of Buffalo.

CHAS. B., whose case is here reported, is of American parentage and a resident of Buffalo, where he was born, which place he never left except on one occasion, when I presented him before the New York Dermatological Society, December 18, 1895. He is eleven years of age, and is apparently strong and robust. His family history is exceptionally good, exclusive of the mother, who died at the age of thirty-three, during pregnancy. His grandparents were noted for their remarkable longevity, his paternal grandfather having attained the age of ninety, and his paternal grandmother having exceeded the age of one hundred and one years; while on the maternal side their respective ages were eighty and seventy-eight.

The father, a locomotive engineer, is forty-four years old, and is seemingly a typical specimen of health and strength. The patient has two brothers, aged respectively seventeen and eighteen, who have always enjoyed the best of health. It was ascertained upon inquiry that the disease from which the patient was suffering had existed in a less marked degree for about a year and a half, and was progressive in its nature.

The patient disclaimed all knowledge of any injury or of exposure to irritating influences of any description. His father was the first to observe the change in the normal skin, consisting of a pink spot slightly raised, below the right naris. There was no pain. At the expiration of three months a perceptible elevation appeared, the beginning of what soon developed into a pronounced ridge. These manifestations—the spot and the ridge—were joined at their margins near their respective centers.

As time went on, the ridge assumed greater proportions, and finally extended to the left side of the nose. My first examination revealed a nodule, irregular in outline, just below the right naris, as seen portrayed in the accompanying illustration (Fig. 1), which was removed some time in August for a microscopical examination.

The character of the nodule was quite superficial, while the tissue beneath was infiltrated and very hard. Upon the right side of the nose two sharply defined ridges were seen, each measuring about an

inch and three quarters in length, having between them a small area of unaffected skin.

The upper one was the least pronounced and was of uneven width. The left side of the nose showed but one ridge, which had a uniform



Fig. 1.

width of nearly half an inch. These ridges, which were exceedingly pronounced and indurated, united upon the bridge of the nose (Fig. 2). The right ala was uniformly thickened, causing a narrowing of the corresponding lumen of the nostril. The left ala, at this time, was not involved. The lines of demarcation between these lesions and the healthy skin were abrupt.

In considering the diagnosis, we may readily eliminate rhinophyma, tubercular lepra, tubercular lupus, keloid, epithelioma, and sarcoma by

the process of exclusion. That this is not a case of syphilis has been demonstrated by the fact that one year's thorough antisyphilitic treatment proved unavailing. The disfiguring growth, its glossy appear-



FIG. 2.

ance and localization, its origin from the nasal mucous membrane—later, its encroachment upon the lower part of the naris, its extension backward in the nasal cavity to the posterior nares, its gradual development without disintegration, its peculiar hardness and elasticity, its extension to the upper lip with a sharp border, and its regeneration of the excised portions—all this has led me to conclude that my patient is afflicted with rhinoscleroma.

The case is one of unusual interest, not alone for its rarity, but from the fact that, so far as records show, this is its first appearance in a person born in the United States. The result of this bacteriological investigation of this case is still in doubt, and when completed it will be made known in a future number of this JOURNAL

EVIDENCES IN YUCATAN AS TO THE POSSIBLE CONNECTION OF PRE-COLUMBIAN SYPHILIS WITH ASIA.

By ALBERT S. ASHMEAD, M. D.,
Norristown, Pa.

LE PLONGEON is of opinion that there is a connection between the Mayas of Yucatan and Asia. In his letter to me, which I gave *in extenso* in my article on pre-Columbian leprosy (*Jour. Amer. Med. Assoc.*, 1895), he says:

"As to Yucatan, where I have resided during eleven years, mostly among the aborigines, I do not recollect having met with a single leprous case among them. There were a few cases of syphilis, where they have had contact with the whites. To-day the Indian population of Yucatan seems to be a particularly healthy, vigorous race. I have seen cases of leprosy, but they were confined to the creoles. Two of the principal families of Merida, the capital, are known to be leprous. Juan Peon Contreras, a member of said families, who generally intermarry among themselves, although very wealthy, was at one time director of the Yucatan Museum, and a disgusting object to look at, literally falling to pieces. Still, he was commingling with other people without hindrance. Another such case I saw at the island of Cozumel. I repeat, the cases are rare. I have no doubt that the disease was known in the country ages before the advent of the Spaniards. The Maya word for leprosy is *naycan*, from the verb *nay*, to corrode, to eat up. This is not a name of modern invention; it is found in the dictionaries and vocabularies of the language made by the Franciscans in the sixteenth century. I have a small medical book written in the Maya language by a native, one hundred years ago, but I do not find in it any mention of leprosy.

"My study of the mural paintings in the funeral chamber of Prince Coh, at Chichen, also of the bas-reliefs that adorn the walls of the public monuments in that ancient city, proves to me that in remote ages the inhabitants of Yucatan, in fact of all Central America, had as close communication with those of all other civilized countries as they have to-day. They had close relations with India and Indo-China, where they introduced their civilization, as I show in my book, Queen Moo and the Egyptian Sphinx, that will be given publicity in two or three months. I discovered portraits of Carthaginians sculptured on the walls; representations of negroes from Africa, Mongolians from

East Asia, Burmese from Indo-China, etc., painted and carved on pillars and walls. In fact, the Nagas, the serpent worshipers, who developed such high civilization in the south of India and the Indian peninsula, were immigrants from *Pâtala* (America), who reached Asia in times anterior to the invasion of India by the Aryans.

"I do not suppose that sailors in those times were more careful than sailors in our days, and I have no doubt that they spread diseases among the inhabitants of the countries they visited, just as the crews of Captain Cook spread syphilis among those of the islands in the Pacific. The communication between Asia and America being then frequent, there can be no doubt that such contagious diseases as syphilis and leprosy were disseminated throughout the earth's inhabitants as they are to-day, and it seems to me impossible to determine where such a peculiar disease originated. We know that at one time syphilis was as common in America as leprosy in East India, and it is most probable that the inhabitants of those countries interchanged compliments; those of America introducing syphilis into Asia, those of Asia importing leprosy into America. . . ."

Mr. Henry C. Mercer, the curator of the section of American and Prehistoric Archæology, University of Pennsylvania, says in a communication that he does not share these views. "I have," said he, "discovered no proof for Le Plongeon's startling deductions as to the age of the Mayas and their migrations, but rather the contrary." He advised me to write to Mr. Edward H. Thompson, of Merida, Yucatan, a fellow of the Royal Geographical Society, who has been hunting about Chichen-Itza and other ruins for ten years or more, and copying the very paintings which Le Plongeon says are representations of negroes, Mongolians, Burmese, etc. This gentleman writes: "Don't build too much on Le Plongeon's theories and claims. Not a single point of contact between the Old and New Worlds before the Columbian era can be proved by monuments or facts so far found in Yucatan or adjoining provinces. The Maya word you quote may have in the olden times referred to leprosy. *Naycam-Kanay* is used *to-day* as the term for a leper. Yet my opinion is that in the old times it was used more for consumption, phthisis. *Nayal* is used when one is fainting from *extreme debility*. I have found many skeletons, but have never observed the evidences of leprosy."

Mr. Mercer referred me also to Mr. Teoberto Maler, who has been exploring sepulchres in various parts of Yucatan for many years, and more recently Peten-Itza and surrounding lands, and who is the correspondent of the German societies. This gentleman, in his reply dated Tieul, Yucatan, November 20, 1895, says: "*Syphilis:* Accord-

ing to the ancient Spanish historians, it seems without any doubt that syphilis is an original American disease, and the Spaniards found it for the first time among the Indians of Haiti, Cuba, etc. It is also true that the ancient Peruvians imitated frequently in clay figures syphilitical accidents; for instance, human faces with the nose eaten away, etc. I saw at Paris, in the Ethnographical Museum of the Trocadéro, many interesting specimens of Peruvian pottery of this kind. This naturally does not exclude that the same disease existed also in China or eastern Asia in very remote times.

"*Leprosy = mal de San Lazaro*, lepra; in German, *Aussatz*. It seems to me that the Mexican Indians are entirely refractory to this terrible disease, which only exists in the Spanish class and mixed people (gente mestizá). Here at Merida and other places of the peninsula many of the principal families are infected with this plague; but I never saw or heard of a true Indian family affected with it, perhaps because the Indians are living principally on vegetable food. The Peruvian antiquities refer, as I believe, to syphilis and not to leprosy; but without doubt leprosy existed also in very ancient times in most of the Asiatic lands.

"Without any doubt the snake, principally the snake head (sometimes treated naturally, sometimes in a fantastic manner with infinite variety), forms the principal element of decoration in Maya architecture. This alone would not be sufficient to establish a relationship (*Verwandtschaft*) with the architecture of the Naga tribes (*Dasyu*), pre-Buddhistic snake and tree worshipers, if it were not for the fact that the Maya architecture has also some other very remarkable resemblances with ancient Hindostan architecture (pre-Aryan), attributable to the *Dasyu* (Naga, etc., perhaps to be counted with the Georgian-Hitit-Thibetan race), and even perhaps to the *Dravidian* style (Telinga, etc., probably of Turanian-Mongolian-Turkish origin). For instance, the Maya triangular arch is the same as the arch used in ancient times throughout Hindostan; and the triangular decoration of the west *façade* of the eastern palace of '*Las Monjas*' at *Uxmal* recalls ancient Hindu wooden structures, in use, for instance, in *Kashmir* bridges till our days!

"It would therefore be interesting to compare the *Maya* language with that of the *Naga* tribes, and also with the Turanian languages of the *Dravida*."

Mr. Maler adds to his letter some quotations from ancient Spanish writers bearing on the subject of pre-Columbian syphilis, which I give here in English.

"*Primitive Historians of the West Indies.* D. A. Gonzalez Bar-

cia, Madrid, 1749, Tomo I.—Oviedo, in his relations ("summary"), in his reports to the Emperor Charles V (conserving the ancient spelling), page 41. . . . Your Majesty may consider as a certain fact that this disease came from the Indies; it is very common among the Indians, but not dangerous either in those countries or in these; on the contrary, the Indians cure themselves very easily in the islands with this Palo (Guayacan), and on *tierra firma* with other herbs and things which they know, for they are very great vegetarians. The first time that this malady was seen in Spain was after Christopher Columbus had discovered the Indies, and turned to these parts, and some Christians who came with him and assisted in this discovery, and those who made the second voyage were more numerous than the first, contracted this plague, and from them it was transmitted to other persons; and after the year 1495, when the grand captain, Don Gonzalo Fernandez de Cordova, passed into Italy with an army to help the King Don Fernando II, of Naples, against King Charles VIII, of France, the man with the thick head, being sent by the Catholic Kings Don Fernando and Doña Isabel, of immortal memory, ancestors of your Majesty, this disease was introduced by those Spaniards, and it was the first time that it was seen in Italy. And as it was at the time when the French came with the said King Charles, the Italians called that disease the French disease, and the French called it the disease of Naples, for they also had not seen it, up to the time of that war, and from these it spread itself through the whole of Christendom, and passed into Africa by the means of some women and men attacked by it, because there is no manner in which it is so contagious as in the coitus of men and women, as has been seen many times; it also is communicated by eating in the dishes, drinking in the glasses and saucers which the diseased persons have used, and still more by sleeping in the sheets or garments of the same; and it is a grave and painful evil. No person who has eyes could help to see a number of people rotten and become lepers (*podrida, i tornada de San Laçaro*), on account of this disease, and many of them have died of it. Of the Christians who have conversation and coitus with the Indian women, few escape this danger, but, as I have said, it is less dangerous there than here, both because there exists there that tree so useful and fresh, it makes more operation (*hace mas operación*), as for that other reason, that the temperature of the land is without cold and helps more those patients than the air and the constellations here." (See note.) *Fernando Colon*, in his historical work, says that the Indians of Haiti gave to this disease the name *caracol*, or *caracacol* (shells), and to the infected *cara caracol* (man-shell), because their skin did become rough as shells.

Tomo II. *Historia de las Indias . . . Francisco Lopez de Gomara*, pagina 24, speaking of the syphilis, says also that the Spaniards did find this disease in the island "Española" = Haiti, etc. . . .

"The inner stronghold," says Brinton, "of those who defend the Asiatic origin of Mexican and Central American civilization is, I am well aware, defended by no such feeble outposts as these (paper-making, tanned leather, cut and polished precious stones, worked feathers into dresses and ornaments, molded pottery, cultivated gardens, names of children after stars and flowers, and so on), but by a triple line of intrenchment, consisting respectively of the Mexican calendar, the game of patolli, and the presence of Asiatic jade in America. I shall attack them *seriatim;* and first for the calendar."

He argues that the calendar of the Thibetan and Tartar tribes, and the Maya tribes, the Nahuas, the Tarascos, and the Mixtecas, are very different in origin; and as the purpose of the Tartar calendar was astronomical, the American calendar was only a ritual formulary. Of this fundamental difference neither Humboldt nor Tylor was aware.

As to the game of *patolli*—the second token of relationship—which, the latter claims, is an adaptation by the ancient Mexicans of the parchesi game of Hindostan, both Mr. Culin, of the University of Pennsylvania, and Mr. Frank Cushing, of the Bureau of Ethnology, agree that there can be no doubt that *patolli* is of a strictly American origin, whatever its partial likeness to the Indian game.

Our author next takes up the article jade, which, he says, Prof. Putnam, of the Peabody Museum, considers to be a powerful testimony to ancient commerce and interchange of arts between America and Asia. "The force of the argument lies in the assumption that certain ancient implements of this material discovered in America are in a variety of it not obtainable outside of southern Asia."

Dr. A. B. Meyer, of Dresden, shows that jade, jadeite, and nephrite are found widely spread over the world in great variety. Dr. Virchow indorses this opinion, and concludes (Congress of Americanists, 1888) that no ethnologic theory can be based upon so ubiquitous a gem. Dieck, at the same congress, says: "We have no occasion to call in the aid of a Mongoloid or Asiatic immigration to explain the presence of these greenstone tools in America." Even recently, as Brinton informs us, Dr. Ernst has found in Venezuela a new locality where jade is found *in situ* on this continent. Yearly, it seems, objects made with this stone come from new regions of America.

"It seems scarcely worth while," says Brinton, "seriously to consider the evidence brought forward from tradition and so-called pre-Columbian history. The hoariest records there or anywhere in

America trace the migrations of tribes for not more than a very few centuries previous to the discovery by Columbus, and, by any fair construction, never beyond a short distance from the nation's central station. Even with regard to the ample and reasonably ancient traditions of the Nahuas of the valley of Mexico, we may safely adopt the opinion of the learned Ramirez, that the geographical area to which they refer will scarcely carry us beyond the limits of the valley itself.

"That there should be frequent parallelisms in the religious traditions, the myths, and the stories of gods and demigods will surprise no one who has extended his studies of comparative mythology over the savage races of all continents. The development of the religious sentiment, the gropings of man in the dark to find out and define to his intelligence the mysterious power which masters the storm, moves the stars, and visits death and life, fate and fortune, on the sons of men, bear in all times and climes an almost fixed relation to the general intellectual development of the individual and the community. The same is substantially true of folklore and of many institutions of social life and family ties. The day is certainly past when an ethnologist of ripe culture will prefer the genealogic to the anthropologic explanation of such similarities, even if they progress to identities.

"The same is doubly true of symbolism. I do not deny that we find on American soil and among primitive American tribes the sacred symbols of the Orient, *svastika* of the Aryans, the *tai ki* of the Chinese, the cross of Christianity. The circle, the quadrilateral, the triangle, the serpent, the bird and the tree, the sacred numbers three, four, and seven, the significant members, the hand, the tongue, and the phallus—all these and many more possessed to the dark-hued tribes of America as mysterious and as pregnant a significance as they did to the worshipers in the temples by the Nile or to the white-robed priests in the isles of Greece.

"This is indeed matter of amazement, food for reflection; but our amazement springs from the consideration how man everywhere different is yet everywhere the same; and our reflection is that, whatsoever is his history, by whatsoever environment he is surrounded, in his slow progress from the darkness of savagery to the light of civilization, he treads the same path, aids himself by the same weak supports, and seeks the same material wrappings in which to swathe the feeble progeny of his intellect and imagination. . . . I maintain, therefore, in conclusion, that up to the present time there has not been shown a single dialect, not an art nor an institution, not a myth or religious rite, not a domesticated plant or animal, not a tool, weapon, game, or symbol in use in America at the time of the discovery which had been

previously imported from Asia, or from any other continent of the Old World."

(On Various Supposed Relations between the American and Asian Races. By D. G. Brinton. *Memoirs of the International Congress of Anthropology*, Chicago.)

Original Text.

Note.—*Historiadores primitivos de las Indias occidentales.* D. A. Gonzalez Barcia. Madrid, 1749. Tomo I.—Oviedo . . . puede V. M. tener por cierto, que aquesta enfermedad vino de las Indias, i es mui comun á los Indios, pero no peligrosa, tanto en aquellas partes, como en estas; antes mui facilmente los Indios se curan en las Islas con este Palo (Guayacan); i en Tierra-firme, con otras iervas, ó cosas que ellos saben, porque son mui grandes Ervolarios. La primera vez que aquesta enfermedad en España se vido, fué despues que el Almirante D. Cristóval Colón descubrió las Indias, i tornó á estas partes, i algunos Christianos, de los que con él vinieron, que se hallaron en aquel descubrimiento, i los que el segundo viage hicieron, que fueron mas, truxeron esta plaga, i de ellos se pego á otras personas: i despues, el Año de 1495, que el gran Capitan D. Gonzalo Fernandez de Cordova, pasó á Italia, con gente en favor de el Rei Don Fernando II. Tóven de Napoles, contra el Rei Charles de Francia, el de la Cabeza gruesa, por mandado de los Catolicos Reies Don Fernando, i Doña Isabel, de inmortal memoriá, Abuelos de V. S. Magest. pasó esta enfermedad, con algunos de aquellos Españoles, i fué la primera vez que en Italiá se vido; i como era en la sazon, que los Franceses pasaron con el dicho Rei Charloes, llamaron á este mal los Italianos, el mal Francés, i los Franceses le llaman el mal de Napoles, porque tampoco le havian visto ellos, hasta aquella guerra, i de ai se esparció por toda la Christiandad, i paso en Africa, por medio de algunas Mugeres, i Hombres, tocados de esta enfermedad, porque de ninguna manera se pega tanto, como del ajuntamiento de hombre á muger, como se ha visto muchas veces, i asimismo de comer en los platos, i beber en las copas, i tazas, que los enfermos de este mal usan, i mucho mas en dormir en las sabanas, i ropa, do los tales aian dormido: i estan grave, i trabajoso mal, que ningun hombre que tenga ojos, puede dexar de haver visto mucha gente podrida, i tornada de San Laçaro, á causa de esta dolencia, i asimismo han muerto muchos de ella: i los Christianos, que se dan á la conversacion, i ajuntamiento de las Indias, pocos ai que escapen de este peligro; pero como he dicho, no estan peligroso allá, como acá, asi porque allá este arbol es mas provechoso, i freseo, hace mas operacion, como porque el temple de la Tierra es sin frio, i ajuda mas á los tales enfermos, que no el aire, i constelaciones de acá.

A NEW METHOD IN THE LOCAL TREATMENT OF ACNE.

BY JAMES NEVINS HYDE, M. D.,
Chicago.

IN several of the forms of acne the local treatment most speedily effective is that first suggested by my friend Dr. George Henry Fox, of New York city. He employs a ring curette, of the kind chiefly used by the gynæcologists, and with this instrument the comedones and pustules of the face displaying the lesions of acne are raked away in a *débris* of pus, blood, sebaceous secretion, and epithelium, with a resulting benefit in many cases which seems well nigh proportioned to the severity of the pre-existing symptoms.

I have employed this instrument for several years with marked advantage in selected cases; but there are distinct objections to its use. These are, first, the painful character of the operation, often a matter of some moment in the case of a young woman with a specially sensitive face; second, a too frequent and unnecessary superficial wounding of the epidermis by the relatively sharp edge of the curette; third, the inapplicability of the treatment to certain forms of acne in which the inflammatory products are subepidermic, or where the disease occurs less in pustular type than with the development of indurated papules.

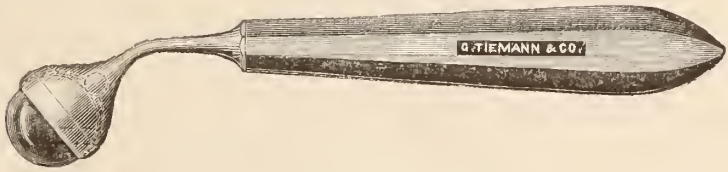
It has occurred to me on several occasions, when making use of the curette, that its value lay fully as much in the degree of massage it produced in the skin of the face as in its action as a knife or as a scraper.

Acting upon this suggestion, I lately devised a massering ball for use in the local treatment of acne which has in my hands produced satisfactory results.

The instrument, figured in the appended cut, consists of a stout and short handle, constructed of hard rubber, and connected by means of a slender steel neck with a ball set in a steel socket, the small sphere rotating within the cup of the latter, as in the ordinary ball-and-socket joint. The free play of the ball in this case is aided by its bearing upon a smaller ball set in the neck of the cup attached to the handle. This handle is fixed upon the socket at an angle sufficiently convenient for the operator, whose eye can thus better follow the play of the ball.

The latter is constructed of hard rubber, and the area of its impact

upon the skin at any moment is about that of the human thumb of average size similarly placed. When actually in use the ball travels with ease as well along the angles of the nares with the cheeks, the bridge and root of the nose, and the regions below the symphysis



Dr. Hyde's massering ball

menti, as over the brow, the temples, the chin, and the cheeks. When necessary to cleanse it, the ball is detached by unscrewing; but the entire instrument may be boiled without damage to its usefulness.

When ready for treatment, the skin is first operated upon with disinfected needle and comedo-extractor (or "comedo-presser," as our English brethren call it) until all pustules and subepidermic foci are emptied and conspicuous comedones removed. After this the surface is rendered aseptic, either with one of the bichloride lotions commonly employed, or, as I much prefer, with a solution of formalin (forty per cent of formic aldehyde) in the strength of from one half of one per cent. to two per cent., according to the sensitiveness of the patient's face. The massering ball is then rotated freely over the surface, and deep pressure is made upon the affected region, with the result of bringing into view gronps of previously inconspicuous comedones which are in turn removed by the extractor or "presser." Lastly, a massage of the surface is practiced with the ball by the aid of a salicylated cocoanut oil or one of the commonly employed sulphur unguents.

All this naturally requires a little time and a modicum of skill, but it is not contended that the process here outlined is a routine method of treating acne in all stages, or even of treating all cases of acne at one stage in its career. The method is suggested as an aid to the management especially of indolent and intractable cases; though I am led to believe that when properly employed it may have a value in others; and possibly also in other diseases of the skin of the face than acne.

The Messrs. Tiemann & Co., who have been interested in carrying out my suggestions in detail, purpose, they inform me, construct-

ing an instrument with several balls attached to a single handle, for the purpose of producing effective massage over the general surface of the body, thus attacking a larger area with greater steadiness and to a greater depth. It is, however, for the local management of cases of acne that the instrument has been specially devised.

THE METHOD OF IRRIGATION IN GONORRHŒAL URETHRITIS.

BY DR. O. J. STEIN,
Chicago.

THE article in the October (1895) number of this JOURNAL by Dr. C. G. Cumston, on the treatment of gonorrhœa in the male by irrigation, causes me to contribute something additional to the mode of applying the treatment, as well as to keep up the stimulation the profession has been of late receiving as to this admirable method in treating all forms of gonorrhœal urethritis.

The treatment of gonorrhœal urethritis by irrigation is not new by any means, but too little attention has been paid to it from the mere fact that the laity, as a rule, consider the disease of no very great consequence, and as a result are not willing to pay the physician sufficient in warranting him to apply a form of treatment that calls for some little preparation, the taking up of some little time, and the exercising of some little labor. For the same reasons the patient can not very easily be induced to carry out this form of treatment at home. It is too much trouble for him to hang up an irrigator and warm a little water, too much annoyance and loss of time to wait until the solution has flowed in and then out of his urethra, and altogether too much bother to finally put the irrigator away, and especially if this is to be done at least once if not twice a day. These objections should not be sufficient to discourage the employment of irrigation in these disturbances, because they are a mere nothing compared with the brilliant results one achieves from their use—brilliant in the ultimate results, the quickness of results, and the lessening in extensions and complications. As we know, the mucous surface of the urethra is bored and drilled pretty well all over, but especially along the floor, by little crypts or follicles and glands. These diverticula are a constant source of embarrassment in one acquiring an attack of gonorrhœal urethritis, in that they afford a most excellent and safe lodgment for the gonococci, and,

by their orifices being in the main minute, their course tortuous, and their situation deep, it becomes impossible to enter these hidden recesses and rout the enemy by any of the ordinary means. Here, then, is where the means of irrigation comes to our aid. But let us not stop simply at the word irrigation, for you might make a perpetual river of your urethras and still not dislodge your enemy because the method—the mode of applying your irrigation—is faulty. By simply introducing a soft-rubber catheter and turning on your hose you do not apply "THE method of irrigation in gonorrhœal urethritis." You must direct your attention to the follicles and the glands wherein lies the *cause* of your disease. What, then, will you do to remove the glandular contents? Open up their orifices. And how? By distending the urethra. You have all seen the anus gape as the head of the child presses upon the perinæum in labor. You have also seen the meatus urinarius open in introducing the vaginal speculum. Just so do the orifices of the follicles and glands in the urethral canal gape and open up when the urethra is distended—distended to nigh its full limit, thus favoring the introduction of the irrigating fluid and the exit of the cocci. Besides opening up these pockets, all nooks and crevices formed by folds in the mucous membrane are exposed, and every part, immediate and adjacent, is brought into full action with the contents of your irrigator. Now, as to the best method of applying this irrigation with distention. In the February (1895) number of the *American Medico-Surgical Bulletin* I acquainted the profession with an instrument devised and used by myself in all my urethral cases. It consists of a fenestrated hard-rubber tube, closed at its distal end by a conical point, while at the proximal end it has a funnel-shaped arrangement similar to the ordinary simple urethroscope in common use. It is made in different sizes and by its introduction the canal is put upon a stretch, the folds are unraveled, the crevices exposed, the orifices opened up, and a most extensive field exposed to our treatment. In applying irrigation I first have the patient urinate, and then pass as large a tube as possible. Into this, down to the bottom of the tube, which, being closed by its conical tip, prevents any secretions or fluid passing back into the deeper urethra or bladder, I introduce a small soft-rubber catheter attached to the tubing of my irrigator and allow the fluid to now flow through the catheter to the bottom of the urethroscope and then back and out, carrying with it the *débris* of the canal. The ribs of the instrument, pressing upon the mucous membrane, disengage any folds and squeeze out the contents of the pockets and crypts which they come in contact with, while that part of the mucosa exposed by the fenestrations by being put upon the stretch allows the openings of its glands to gape. By then gently

turning or removing and reintroducing the instrument, the solution used may be brought into contact with the entire field of the canal.

Another method may be applied by simple distention with hydraulic pressure on the principle which is employed in aëro-urethroscopy, where the canal is distended with air for the purpose of examination and diagnosis. Here a close-fitting, conically shaped tube may be employed, closed at its proximal end, and with two openings, the larger for the attachment of an ordinary bulb syringe whereby the solution may be pumped in, and a smaller one as outlet. But the objection here is that relaxation of the compressor muscle will allow the washings to enter the deeper regions, exposing them to contamination; and then, too, it is a more painful procedure and not entirely devoid of danger.

I have endeavored by the foregoing remarks to bring to your recognition the importance of distention in conjunction with your irrigation. Unravel the mucous membrane, open up the orifices of the glands and follicles, press out their contents and allow the solution to permeate every part of the passage. The attack must be made at the very citadel of the disease. Then and only then will you have speedy and satisfactory results. As to the solution employed in the irrigation, I prefer the permanganate of potash in strengths varying from 1 to 5,000 to 1 to 2,000. But any kind of solution may be used by employing my fenestrated tube, for, being made of hard rubber, it is not in the least affected.

The instrument may be had from Frank & Kratzmueller, Chicago, who make it in three sizes, Nos. 23, 26, and 28 of the French scale.

AN EXTENSIVE CASE OF TINEA CRURIS.

By J. ABBOTT CANTRELL, M. D.,

Professor of Diseases of the Skin in the Philadelphia Polyclinic and College for Graduates in Medicine; Dermatologist to the Philadelphia Hospital and to the Southern Dispensary, Philadelphia.

THE following case, which appeared in my ward service of the Philadelphia Hospital, presented such an extensive condition that I venture to record it. At my visit to the wards of the hospital, the first case to claim my attention occurred in a young man twenty-nine years of age, who stated that he had been a hostler for the previous nine or ten years and had never had a similar condition. It

had existed, as far as he knew, for the previous two or three months, and had never given him any discomfort; there had been no itching or other disagreeable symptom, and he only became aware of its presence after having attended several horses which had been suffering from what he termed the scratches.

It appeared upon the left side of the groin as a small papule, which was raised slightly above the normal skin. It began to spread and has grown until the disease occupies the area which is now involved. He is unable to give any good account of how or when the upper or chest lesion appeared.

The upper lesion occupies the entire chest, which is totally devoid of hair. It is irregular in outline, its upper border being marked by the clavicles on either side and the lower by the position of the ensiform cartilage—dipping down as it does between the nipples, which mark the lower portion on either side. Upon the left side it extends about two inches beyond the nipple, while on the right a line drawn from the nipple upward marks its border. In color the surface presents a brownish red. The edges are here and there marked by a vesicle, which in the majority are small.

The lower lesion, which is more extensive than the above mentioned, occupies mostly the abdomen and genitalia. The upper border is about one inch below the lower border of the upper one, with the exception of the sides, where there is some intervening healthy tissue. The sides of the patch are marked by the outer borders of the abdomen, while the lower dips down below the pubis for about four or five inches, and over the genitalia and crural regions. The surface of this lesion was much darker than that upon the chest. No vesicles were found on the borders of this lesion. At the time in which I witnessed this case a microscopical examination was made from particles taken from both patches, and both showed the trichophyton fungus; but, unfortunately, the account of this examination has been mislaid and I am unable to give it, more than to state the fact of its having been made. There were no lesions visible on other portions of the body, although they were earnestly sought for by myself and assistants.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

Alimentary Regimen in Skin Disease.—This question has been raised in the past year at the reunion of the British Medical Association by Drs. Allan Jamieson and Walter G. Smith. In their communications they made many noteworthy observations, and it appeared to us a time for an article on the same subject, a paper which has just been published in Berlin, and of which we give a *résumé*.

I. If anything approaching an exact account of the rôle played by diet in the cure of skin disease is to be given, it is necessary, as we have already demonstrated in our various publications, to study both its immediate and remote effects. As to the immediate possible effects of certain substances on the integument almost all dermatologists are in accord. It is in reality a common conception that certain foods may in a space of time varying from several minutes to forty-eight hours after their ingestion provoke an eruption of urticaria, erythema, or acne. The latest researches published on these toxic effects confirm this idea.

We may cite among the foods which may excite immediate accidents in the skin certain sea fish, such as goldfish, caranna, sardines, herring, mackerel, salmon, ray, etc.; shellfish, such as oysters which are not fresh, clams; crabs, smoked and preserved meats, forced meats, pork, etc.; salted and fermented cheese, which gives rise so often to eruptions of acne and folliculitis; certain acid fruits, berries, nuts, almonds, truffles, sweets, pastry, etc. As to the various alcoholic drinks, to imported beers, acid wines and liquors, to coffee and tea, their harmful rôle is not admitted by all physicians. It is probable that these substances act more especially after a length of time in which constant use has been made of them.

The articles of food just enumerated may have an immediate pathogenetic action in themselves, determining a true acute intoxication of the economy or provoking stomach or intestinal disturbances which react on the whole organism, or finally, as W. G. Smith says, by the elimination through the skin of the irritant substances. It is easy to see, then, that the methods of preparation of food must also enter into the discussion. Certain persons can not take butter, especially if rancid or adulterated; others, fat; others, oil; some are unable to bear spices; others, rare meats, etc. Further, when the immediate effects of alimentation on the organism are in question, it is necessary to take note of the slightest individual susceptibility. There are persons who can eat game with impunity, and who have urticaria when they undertake veal, turkey, or eggs.

Individual susceptibilities are often so exquisite that the slightest particle only of the offending substance suffices to provoke the eruption. I knew a person who could not eat from a dish, in the sauce of which there had been one or two mussels, without being seized with serious symptoms of intoxication. At the end of fifteen to twenty minutes she had flushings, cold sweats, loss of consciousness, then vomiting and urticaria.

It is evidently not logical to interdict to a given subject all the food products which may occasion an eruption in him. He must make a study of his own susceptibilities, and remove little by little from his dietary all the substances he knows will be harmful to him, and these alone. Individual susceptibilities may, moreover, be modified with age.

II. The problem is more difficult when disorders are to be studied which an alimentary substance in frequent use may produce in the organism remote from its time of ingestion. When it is forbidden to the patient he invariably answers that he knows it does him no harm because, having partaken of it that day or the day previous, he has not felt any ill effect ; and many dermatologists regard this action as a prejudice, a relic of ancient medical superstitions. Until exact laboratory experiments have demonstrated the fact, we can not admit it. Nevertheless, it must be observed that the kind of alimentation influences remotely in a most evident way the skin and hair of animals, as numerous experiments have proved. Scurvy also develops late in subjects deprived of fresh vegetable diet, and pellagra seems to be produced especially in the train of defective nourishment.

The question of the injury done to the skin by certain foods used habitually recurs to this—whether slow, gradual accumulation of toxic principles in the economy predisposes to certain dermatoses. We assert positively, in accordance with numerous facts in our observation, that not a few eruptions are external indications of general conditions whose most frequent and least harmful manifestations are known at the present time in France under the names of *arthritisme* and *nervosisme*. Certainly, the subjects may inherit from their parents various temperaments, a tendency to asthma, renal or biliary lithiasis, migraine, visceral neuralgias, etc., gout, eruptions of a lichenified eczematous type—in a word, the diseases of faulty nutrition (*arthritisme*). They may as well have inherited a nervous impressionability (*nervosisme*). Still, there is no doubt that these various morbid states may be entirely acquired, or at least exaggerated, in patients predisposed by heredity.

If alimentation sins on the side of excess, of insufficiency, of poor quality of the ingesta, of the non-adaptation to the locality and climate in which the person lives, whether the food be badly digested or imperfectly elaborated in the organism, whether the excretory functions (lungs, skin, kidneys) be vitiated in their action, there accumulate little by little in the liquids and organs of the economy various excrementitious products more or less toxic which remotely impress on the organism a vital depreciation and a morbid vulnerability. We know that individuals having a dietary too substantial for the work they do, using besides alcohol, coffee, tea, kola, cocoa, leading a sedentary life in the great cities, taking no exercise and having none of the oxygen of the fields to consume the offending products, little by little acquire gout; this is the popular idea. How is it possible to say that the skin is the only tissue in the body which escapes a general intoxication ? We have often seen in a gouty subject, either hereditary or acquired, cutaneous manifestations in the shape of a bullous or erysipelatoid eczema, again as acute cutaneous accidents of a type of lichenified eczema or chronic circumscribed neurodermitis, chronic cutaneous accidents alternating with visceral or articular gouty crises. It is therefore not illogical to believe that habitual bad feeding may not be foreign to the development of these eruptions.

The same is true of nervous excitability. It may without doubt be heredi-

tary; often also it is acquired, or at least the hereditary predisposition is developed in a remarkable way under the influence of certain causes, such as the surroundings, cares, dwelling in great cities; but it is often necessary to implicate certain chronic intoxications, such as alcoholism, theism, coffeeism, cocainism, and kolaism. For several years, in our polyclinic of La Rochefoucauld, we have sought the antecedents of coffeeism in patients who came for consultation as to pruriginous dermatoses. We found them constantly.

It appears logical to counsel eczematous arthritics to follow a suitable regimen in order to escape from new eruptive attacks; they should abstain from coffee, tea, liquors, wines, alcoholic drinks, heavy meats, berries, tomatoes; their diet should include most green vegetables. Neuropathic subjects attacked by a pruriginous dermatosis should avoid coffee, tea, alcohol, kola, cocoa, and highly seasoned foods. Patients with pustular acne should not eat cheese, preserved meat, or fish. Those who have rosacea must avoid alcoholics.

Further, when the subjects are threatened with a disease attack, various foods may play in them the rôle of occasional cause and have an immediate pathogenic effect. They may at the time exercise an immediate baneful influence, provoke an attack, and cause a distant outbreak.

III. It is not necessary for the physician to apply blindly the rules we have just enunciated. They must often be modified, and it is this which dermatologists, occupied with this question, appear to us not to have fully understood.

If an eczematous arthritic, accustomed to the sedentary life of cities, is taken to the country and made to exercise in the open air, he could, without inconvenience, modify his diet and take alcohol, coffee, and tea, provided that he did so only in a quantity proportional to the physical exercise undergone. An inhabitant of the country, mountain, or seaside has no need to follow the same rigorous regimen as an office employee in a city.

Again, fresh food consumed on the spot may be harmless, while it becomes injurious when transported to a distance. This often happens in the case of fish and crustacea, which certain people may eat with impunity at the seaside and can not endure when found in the interior. A man from the north, in whom a nervous impressionability does not exist, who needs substantial nourishment to resist the action of cold, who consequently must consume a great deal to produce heat enough, eats with impunity what would intoxicate in a few weeks in a temperate climate. Smoked sausages, preserved fish, tea, coffee, and alcohol are tolerated in a wonderful way by his organism and have no effect on his skin.

The Scandinavian, Anglo-Saxon, and Germanic races are by their constitution and the climate of their countries freed from a majority of the inconveniences of diet. The Latin, Oriental, and Jewish races have, on the contrary, in this regard the greatest susceptibility. If an individual makes a change of climate he should modify his diet. Going into a colder country, he could consume without inconvenience food and drink which he could not endure in his own country. Changing to a warm climate, he should have a more frugal dietary and abstain totally from alcohol. There can be, then, no line of invariable conduct: dietetic prescriptions must vary according to (1) the race, the nationality of the patient; (2) the country he inhabits; (3) his heredity and morbid predispositions; (4) the state of his organs; (5) his mode

of life and the place in which he lives—city, country, mountain, or seaside ; (6) and especially according to the skin disease from which he suffers, for all cutaneous affections are not benefited by the same dietetic prescriptions.

Local Anæsthesia in Dermatology.—Perfecting of the varied procedures known as local anæsthesia employed in the numerous small operations of cutaneous surgery which become more and more the order of the day, is continually going on. Dr. Dubreuilh, of Bordeaux, has recently reiterated the advantages of cocaine. He recognized, like many others, that in friction or application made on the skin surface the substance is not efficacious ; it must be injected. Since the solution must infiltrate the tissues to be anæsthetized in order to reach the nerve terminations, the injection ought not to be subcutaneous, but intradermic. It must be injected into the superficial denser layers of the derma, from which it is easily diffused into the lower and looser layers. He uses a 2-to-100 solution ; as a vehicle he has adopted a mixture of equal parts of distilled and cherry-laurel water, which keeps well. He never uses more than two cubic centimetres (four centigrammes of cocaine) in a patient on whom he is operating for the first time, and he very rarely employs more than three cubic centimetres (six centigrammes of cocaine) even in subjects previously anæsthetized. He makes the injection with a syringe of a capacity of forty-five at the border of the field of operation, in order to be able to cover the whole region in the derma as near as he wishes to the surface. When the syringe is engaged in the skin several drops are injected; the needle can be pushed on parallel to the surface, and every five to ten millimetres a little liquid is driven into the tissues. When the injection is finished there is seen about the point of the needle a white area ten to fifteen millimetres in diameter, which is due to the compression of the vessels by the fluid and to the contraction under the influence of cocaine. The zone corresponds exactly to the anæsthetized area. With half a Pravaz syringe and a single puncture a band of tissue three to three and a half centimetres by one centimetre wide may be anæsthetized in fifteen to twenty minutes. In certain regions, such as the tip of the nose, the nostrils, fingers, a very fine needle and multiple punctures are necessary. When the skin is too thin for endermic injections subcutaneous punctures suffice.

Dr. Just Lucas-Championnière recommends as a harmless and certain local anæsthetic subcutaneous or intradermic injections of guaiacol, which one of his pupils, M. Quidré, first employed. An oily solution containing five centigrammes of guaiacol to the Pravaz syringe is used. This drug first came into use in dental surgery, but lately it has served a purpose in small operations. Subdermic injections of guaiacol oil give complete local anæsthesia in five to ten minutes. This method seems likely to replace little by little that of cocaine injection, for the guaiacol is much less dangerous. The olive oil used as a vehicle must be pure, or it may produce tiny scars at the edge of the puncture.

It is the same with guaiacol otherwise as with cocaine : when it is used in inunction in the form of ointment, of oily solution, or even in the pure state, it produces only a very hypothetical anæsthesia. It seems, however, that after friction of the skin of the members with pure guaiacol a certain degree of insensibility is obtained at the end of ten to fifteen minutes which favors electrolytic operations. It is necessary to take into account, in such a case,

individual susceptibility, for there are many skins which bear such applications badly.

For all electrolysis operations, when they are to be done on a large surface, injections of cocaine can hardly be used, because they must be too often repeated and become dangerous. The method which has given me least objectionable results is a mixture of chlormethyl and chloride of ethyl, which is directed in a fine jet on the part to be operated on. This stream, thanks to a simple mechanism, can be turned on and off with one hand according to necessity. L. BROCQ.

Society Transactions.

THE NEW YORK DERMATOLOGICAL SOCIETY.

248TH REGULAR MEETING, HELD ON TUESDAY EVENING, DECEMBER 17, 1895.

DR. C. W. CUTLER, *President, in the Chair.*

A Case of Atrophy of the Skin.—Presented by DR. GEORGE T. JACKSON.

The patient was a man about fifty years of age, with marked atrophy of the skin of both lower limbs ; the condition was especially well marked about the knees. It had commenced many years ago without any apparent cause. Below each knee was an eczematous patch which had persisted for a long time.

DR. H. G. KLOTZ said the case interested him very much because he had seen two similar ones, one of which he showed to the society several years ago. In one of his cases there was atrophy of the skin of both lower extremities, extending as far up as the lumbar region ; the patient traced it to an injury he received, having been run over by a wagon. Dr. Klotz said he saw this man recently, and on examination it was found that the condition had somewhat improved. As in this case, there were eczematous patches on the affected limbs. In the second case that came under his observation the atrophy was confined to the ulnar side of one forearm and had appeared after an injury of the elbow. The speaker called attention to the remarkable prominence in the veins in these cases, which seemed to undergo but slight changes. He stated that if an injury is the cause of this atrophy of the skin, it can only be through trophic influence.

DR. GEORGE T. ELLIOT said that before deciding as to the nature of the case presented by Dr. Jackson it is important to know whether the eczematous condition preceded the atrophy or *vice versa*. It is of course possible to have an eczema complicating a case of idiopathic atrophy of the skin, but the only way to decide this is by the patient's history. In some respects the case resembles Dr. Bronson's case of idiopathic atrophy.

DR. SHERWELL said that he had remarked the similarity between this case and the one reported by Dr. Bronson. He looked upon the condition at and above the knee as primary. Many and various atrophic conditions of the skin had come under his notice—one most peculiar, which he would like to

speak of in this connection, having tried in vain to get her to come to one of these meetings. It occurred in a person of about forty-five years of age, a female domestic. She had fallen on a ferryboat, striking and injuring her head, the concussion of the boat with the dock being the cause. She had lameness (partial paralysis ?) of arm, etc., following ; the most striking atrophy of skin over the neck, part of the back, and one arm had followed ; the muscles were not particularly affected. He supposed this lesion had been caused by some disturbance of the central nervous system.

Dr. Bulkley said he did not think the atrophy of the skin in this case was in any way dependent upon the eczematous condition, which he regarded as simply secondary. The atrophy is especially marked over the knees, where there is no eczema, and extends beyond the point of eruption. The speaker referred to a case of atrophy of the skin coming under his observation in which the condition was confined to one hand, and was due to an injury of the ulnar nerve.

Dr. J. A. Fordyce said he regarded the atrophy as primary and the eczema as secondary. In a case of this nature, the condition of the reflexes, and of the nervous system generally, should be investigated. Progressive atrophy of the muscles occurs from degeneration of certain cells of the spinal cord, and it is probable that certain central nerve cells preside over the nutrition of the tissues of the skin.

Dr. S. Lustgarten thought the case was one of primary atrophy with secondary changes in the parts where the skin is stretched over the underlying shaft of the tibia. The causes of the atrophy are enigmatical. In an old man with atheromatous arteries, it is quite probable that it is due to degeneration of the blood-vessels, followed by atrophy of tissue. A nervous cause seems quite absent in this case.

Dr. Klotz said that in both the cases he observed, the atrophy preceded the eczema. The former did not cause any inconvenience, and it was not until the eczema appeared that the patients sought medical advice.

Dr. Elliot said he merely wished to emphasize the importance of a complete history in these cases. In hospital practice it is not uncommon to see patients with a chronic dermatitis, particularly of the lower two thirds of the leg, which has existed for a long time, and in many instances produces a primary thickening of the skin, followed by considerable atrophy. Such cases are classed as varicose conditions of the leg, chronic dermatitis, etc. In the case shown by Dr. Jackson the history does not state whether the condition of atrophy was primary or the result of a preceding eruption.

Dr. Bulkley said he had never observed such a pronounced atrophy of the skin as was present in this case result from an eczematous process. The skin, too, is very movable, and is thin, paperlike in quality, which is quite distinct from what we see after a chronic dermatitis.

Dr. Jackson, in closing the discussion, said that on account of the stupidity of the patient it was impossible to get at the true history of the case. He did not know when the atrophy or the eruption first appeared. He had been under observation at the Vanderbilt Clinic for nearly two years, and during that time the condition had changed very slightly. The eczema had never extended to the knees, where the atrophy was most marked. The speaker said he had always regarded the case as one of idiopathic atrophy of the skin.

A Case of Fungating Growth on the Nose and Lip.—Presented by DR. G. H. FOX.

This patient, who was presented by Dr. Fox at the previous meeting of the society, was a young man who was struck on the nose and lip by a horse's head. The nose bled and was slightly abraded. The wound had almost healed, when suddenly it grew worse, and crusted pustules developed on the nose and upper lip which resembled the lesions of contagious impetigo. These lesions rapidly developed into rounded tumors of a soft, spongy, fungous character, which readily bled.

Dr. Fox stated that, under the use of nitrate of silver and a solution of carbolic acid, the eruption had slightly improved, but since the previous meeting the growth had extended somewhat up the nose. The lesion on the lip still persisted; that on the nose did not look like an ordinary granuloma.

DR. ELLIOT said he still regarded the case as one of infectious granuloma. It was certainly much better than it was at the previous meeting.

DR. C. W. ALLEN thought the improvement in the appearance of the lesion was marked. He saw no reason to change the diagnosis.

A Case of Rhinoscleroma.*—Presented by DR. G. W. WENDE, of Buffalo, N. Y. (by invitation).

DR. JACKSON said he thought there was no doubt about the case being one of rhinoscleroma. It had almost all the clinical features of that disease. He thought it remarkable to see the disease develop in so young a subject, particularly as the boy was born in this country, of American parentage.

DR. ALLEN said if the case was one of rhinoscleroma, as he believed it to be, then it was probably not the first case of its kind discovered in this country nor developing in this country, but the first to be observed in a native.

DR. BULKLEY said he had no doubt that the diagnosis was correct. He had never seen the disease in so young a subject. Many years ago a case came under his observation in which a similar growth to this involved primarily the right ala of the nose. The patient was a girl about twenty-six years old, a native of Plainfield, N. J. The case was never reported; no microscopical examinations nor attempts at cultivation were made.

DR. KLOTZ said he agreed with the diagnosis of rhinoscleroma. He wished to report on this occasion on the progress of the patient whom he presented to the society over a year ago. At that time there was a new growth at the base of the nose, which he destroyed with the galvano-cautery, and since then the disease has remained quiescent in that location, although it has since involved the superior maxilla to such a degree that the upper lip was pushed upward and forward. A large part of the soft palate is atrophied and the uvula is destroyed. He has had his case under observation for six years, and the patient's outward appearance has hardly changed since.

DR. FORDYCE regarded the case as one of rhinoscleroma. He thought it rather surprising that no bacilli were found. In two cases he had examined he found no difficulty in staining the germs by Gram's method.

DR. ELLIOT also agreed in the diagnosis.

DR. LUSTGARTEN said he thought there was no doubt that the clinical diagnosis was correct. He had found that while in some cases the bacilli are stained with ease, in others it was very difficult to stain them. As this is one

* See page 90.

of the few cases, if not the first, that has been reported in a native of this country, it would be well to verify the diagnosis by finding the bacilli. In several cases which he had occasion to study while still in Vienna, cultures of the bacilli could be easily obtained. This was also the experience of the discoverer of the rhinoscleroma bacillus, von Frisch, of Paltauf and Kolisko, and others.

Dr. Fox also regarded the case as one of rhinoscleroma.

A Case of Lichen Ruber Acuminatus (Hebra, Kaposi), or Pityriasis Rubra Pilaris (Devergie, Besnier).—Presented by Dr. Lustgarten.

The patient was a boy twelve years old. The disease was either congenital, as claimed by the nurse (although the mother denies it), or it originated at a very early period. It has not interfered with the physical or mental development of the child. The palms and soles have escaped the eruption. The disease shows exacerbations and periods of remission.

Dr. Fox, who saw the patient some years ago, showed photographs of the case taken at that time. These photographs showed a distinct flattening of some of the lesions, with a central umbilication.

Dr. Fordyce said he thought the case was one of pityriasis rubra pilaris, although in some respects it very closely resembled psoriasis. The two conditions, he thought, were in some manner related to one another.

Dr. R. W. Taylor expressed the opinion that the name lichen ruber, which was given to this disease by Hebra, should be retained. His original description of the condition still remains a classic, and it is unfair to supplant it by the name given to it or claimed to be given to it later by Devergie.

Dr. Lustgarten said that in this case the disease began at an earlier period than in any other case on record. It was possible that it was congenital. As regarded treatment, he had found that local applications similar to those employed in psoriasis (pyrogallic acid, chrysarobin, etc.), would relieve the condition only temporarily. Internally he had employed arsenic, pilocarpin, and thyroid extract in large doses and for long periods without any benefit. As regarded the proper name for this condition, Dr. Lustgarten said that even if we accept the newer name of Besnier we are by right bound to mention the older one of lichen ruber acuminatus given to it by Hebra and Kaposi.

Dr. Bulkley suggested the use of tartrate of antimony given in tablet form combined with ipecac (1-100th of a grain each). One of these should be given every two hours until some action on the skin was produced, but stopping far short of nausea.

Dr. Fox said these patients improved very much at certain times. Dr. Taylor's case was entirely well for a time, and then had a relapse for which no cause could be found. The cases usually continue having relapses until they died ; he had never seen one recover permanently.

Dr. Fox also exhibited a number of photographs showing cases of erythema multiforme which appeared after vaccination or the administration of copaiba.

Report of Cases presented at Previous Meetings.—Dr. Fordyce said that two months ago he presented to the society a patient with a peculiar affection of the lips. He had recently received a letter from this patient stating that several members of his family are similarly affected, while others have had it in the past. As they grew older it became less marked or disappeared. Dr. Fordyce said that a few days ago he saw an exactly similar case, which went to show that the condition was not so rare as was supposed.

DR. SHERWELL within a very few days had had a case of intense erythema following ingestion of a very moderate dose of quinine. It curiously enough happened to a young woman (who was apparently healthy and of blooming and robust type), who as a girl had suffered from pemphigus foliaceus of Cazenave, and whose history, and that of a subsequent relapse after cure, had been reported in the *Archives of Dermatology* (*vide* pp. 97–100, January, 1877). The case soon recovered from this erythematous condition on suspension of the drug.

NEW YORK ACADEMY OF MEDICINE

SECTION ON GENITO-URINARY SURGERY: STATED MEETING, HELD ON TUESDAY EVENING, JANUARY 14, 1896.

DR. ALEXANDER W. STEIN, *President, in the Chair.*

The Technique of the Amputation of the Penis.—DR. RAMON GUITERAS read a paper with this title. He confined his remarks to the anterior operation, and did not consider the so-called extirpations where the urethral orifice is made in the perinæum. He stated that up to the present time no perfect operation for the amputation of the penis has been devised. The principal complications are, (1) hæmorrhage, (2) retraction of the orifice of the divided urethra, (3) narrowing of the orifice due to contraction of the cicatricial tissue, and (4) wetting of the wound by urine.

In order to overcome the first objection, namely, hæmorrhage, it is necessary to tie a rubber band or an elastic catheter about the base of the penis until the amputation is completed; the larger arteries should be tied with fine catgut; bleeding from the smaller ones can be checked by the application of hot water and proper dressing.

The second complication, namely, retraction of the divided urethra into the stump, can be guarded against by cutting the urethra at a lower point than where the body of the penis is removed; it should be left at least half an inch longer than the body itself. Narrowing of the orifice of the urethra, due to constriction or contraction of the cicatricial tissue, is probably the most serious obstacle that we have to contend with, and surgeons generally try to overcome it by stripping up the urethra on its dorsal or lower aspect. If the end of the cut urethra protrudes sufficiently far, and is then well united to the skin, a better orifice will result. If contraction occurs, meatotomy may be necessary. Wetting of the wound surface by urine is difficult to overcome, and always interferes with healing. To obviate it the retention of a soft catheter is generally advised.

Dr. Guiteras then described in detail the steps of the operation he employs in amputation of the penis, which, except on the point of more careful technique, presented no new features.

In making the amputation both the urethra and the flaps of integument are allowed to remain half an inch longer than the body of the organ, and are held by retention sutures. To facilitate the operation, a sound is inserted into the urethra, and on its completion it is replaced by a No. 10 French catheter, which is left in for a few days.

Dr. R. W. Taylor said that in many cases of cancer of the penis, for which amputation is generally performed, the urethra either can not be found or is so occluded and distorted that a sound can not be passed. The method described by Dr. Guiteras would therefore be only applicable in those cases where this stenosis does not exist. The speaker said that many years ago he adopted a little procedure in these operations which has always given good results. This he described as follows : Assuming that he has to deal with a case in which the cancer involves the anterior third of the organ, he first crowds the integument back toward the pubes, at the same time pulling the corpora cavernosa forward ; then two long hat pins are thrust through the corpora cavernosa in an oblique direction, one on each side, thus forming an X. These pins give him perfect control of the organ. In the formation of a urethral orifice, we should be guided by our knowledge of anatomy. If only one or two or even three inches of the penis are removed, the incision into the corpus spongiosum should be vertical, for the reason that thus far the urethra is a vertical slit: farther down, where the urethra is a transverse slit, the incision should be transverse. The corpus spongiosum should be allowed to protrude three quarters of an inch beyond the amputated end of the corpora cavernosa. The tegumentary sheath should be allowed to protrude for about the same distance, and when the amputation is completed this will push forward and form an overlapping flap, which is stitched to the margins of the corpora cavernosa. The stenosis that occurs is not from the urethra itself, but from the fibrous tissue surrounding it ; if early dilatation with soft bougies is commenced, the contraction will gradually be overcome.

Dr. L. Bolton Bangs said the little device mentioned by Dr. Taylor, which he has employed several times, certainly affords a complete and satisfactory way of controlling the penis. He has never observed any serious contraction of the meatus follow the operation. The slight contracture of the aperture often seen has been only sufficient to project the stream of urine. He referred to one case operated on by Dr. F. N. Otis, in which the galvanocautery was employed to sever the corpora cavernosa ; this was done very slowly and produced an admirable result. There was no secondary hæmorrhage.

Dr. Guiteras, in closing the discussion, said that he has usually been successful in introducing an instrument into the urethra in these cases, sometimes a very small filiform bougie, followed by a sound of larger caliber. Slight mutilation of the anterior part of the organ is of no consequence, as it is to be amputated. The introduction of even a very small instrument will answer the purpose.

The following officers were elected for the ensuing year : President, Dr. William K. Otis. Secretary, Dr. Ramon Guiteras.

Book Reviews.

The Pathology and Treatment of Venereal Diseases. By ROBERT W. TAYLOR, M. D., Clinical Professor of Venereal Diseases at the College of Physicians and Surgeons, New York; Surgeon to Bellevue Hospital, etc. Lea Brothers & Co., Philadelphia, 1895.

Dr. Taylor is certainly to be congratulated on his work, of which he can justly be proud. The volume consists of one thousand pages. The first part is devoted to gonorrhœa and its complications, the second to chancroid, and the third to syphilis. The illustrations, of which there are many, are well selected, and in large measure original; they are also well executed. The references to literature bearing on the subject are so extensive that the book will be of much value not only to the general reader, but particularly to the specialist. A detailed review of the work would not be practicable, owing to the space it would consume, consequently a few only of the important points will receive comment. The ætiology of gonorrhœa, with special reference to the gonococcus, is fully considered, and much credit is given to Neisser. Taylor, however, considers that just at present there is a tendency on the part of the profession to exaggerate the longevity and the persistency of the gonococcus, and he rightly holds that the teachings of such gynæcologists as accept the theory of Noeggerath are too extreme. In the treatment of acute gonorrhœa conservatism is advocated, and in this connection mention is made of the many local measures which are being continually brought forward year by year with the object of cutting short or aborting the disease. These measures are spoken of as fads, and among them is classed Janet's method, which is at present occupying considerable attention. Taylor believes with the great majority of the profession that stricture-cutting, in connection with the anterior urethra, has been very much overdone. In speaking of the endoscope, the author says: "As a means of localizing an inflammatory focus, of viewing surface appearances, and of allowing the use of topical applications under free ocular inspection, it is often of signal benefit. It is an instrument of reserve rather than of routine, and it always should be used in a rational and conservative manner. It is to be regretted that it has been used very much as a toy, and has been to some simply a surgical hobby."

The last half of the book is devoted to syphilis. In this connection Taylor properly holds that it is better, except possibly in a few exceptional cases, not to begin a mercurial course until the advent of secondary symptoms. He does not believe in the tonic or continuous treatment of syphilis, and thinks the protiodide of mercury a drug of little value, except perhaps during the early secondary stages of the disease. He considers that every case should be separately studied, and that mercury in the form most suited to the individual should in each instance be prescribed. The greatest importance is attached to a vigorous mercurial course, commencing during the early secondary stage and continuing for six months. In this connection the author states: "Having administered an efficient treatment with few and short interruptions for about six months, it is safe to say that in most cases, particularly uncomplicated ones, the patient will be well on his way to recovery."

Although this idea may contain considerable truth, still, if it is adopted by the general profession, the results following it will not be so good as those obtained from Keyes's tonic or continuous treatment, of a moderate dose of mercurial taken over a much longer interval. There is no doubt that a heavy course of mercurial during the first six months of treatment is wise and of especial value, and then after that heavy medication, if symptoms call for it, or light medication more or less continuous over the next year and a half, even though the disease may be quiescent. The great safety for one suffering from syphilis lies in careful supervision over a period of two and a half to three years under the eye of his medical attendant. If the patient gets the idea that six months of vigorous treatment is sufficient to cure most cases, he will be apt to drop his doctor at the end of that time, and very likely to forget in great measure his indiscretion, with the result that later on his disease, being allowed free play, may develop serious lesions.

Eugene Fuller.

Pathology and Treatment of Diseases of the Skin, etc. By Dr. Moriz Kaposi. Translation from the last German edition under the Supervision of James C. Johnston, M. D. Pp. 684. William Wood & Co., Publishers.

After having received the compliment of several German editions, after having been translated into several other languages besides French, in which it has been exhaustively annotated by Besnier and Doyon, it is only at this late date that Kaposi's *Pathology and Treatment of Skin Diseases* has been rendered into English and its valuable contents made accessible to those physicians who are cognizant of no other language. The author's position as the successor of Hebra to the chair of dermatology in Vienna places him as the foremost exponent and representative of the Vienna school, and in this work the traditions and points of view of that school are strictly adhered to and unreservedly emphasized, though the doctrines and teachings of dermatology in more recent times receive a certain proportion of recognition. The work opens with an historical review of those who have contributed to the advancement of dermatology, but among these we regret not to find the names of Duhring, White, and other Americans. The succeeding chapters deal with the anatomy, physiology, general symptomatology, ætiology, diagnosis, and therapeutics, and then, following Hebra's classification, we find the various pathological conditions and changes in the skin treated of successively. Hyperæmia and anæmia receive due attention, and then the diseases of the sweat glands are taken up. Among these Kaposi ascribes osmidrosis entirely to decomposed sweat and the formation of the fatty acids or to certain diseased conditions, no reference being made to the influence of microorganisms, the *Bacillus fœtidus*, etc.

He regards eczema intertrigo as due to retained sweat, and includes under the term dysidrosis both hyperidrosis and anidrosis, while chromidrosis, hæmatidrosis, etc., are anomalies of secretion. Pompholyx he considers to be an eczema, an accompaniment of hyperidrosis. In regard to intertrigo and pompholyx, we can not think that the opinions given can be generally accepted. The symptoms characterizing the former are too distinctive and variable to be the result of sweat retention alone, and that the latter is not a simple accompaniment of hyperidrosis, and is unconnected with the sweat

glands, has been abundantly shown by the Hoggans, Crocker, Thin, and Robinson.

In treating of functional diseases of the sebaceous glands, we find seborrhœa sicca and oleosa, the former supported, however, by not a particle more of proof than was brought forward by Hebra, and no cognizance taken of the many facts brought forward by various writers as to the non-existence of such a condition pathologically considered.

After the acute exanthemata, variola, scarlatina, etc., which are admirably described, Kaposi takes up the group erythema. The multiform variety he ascribes to the effects of the seasons, which suggest a miasmatic and bacterial origin. He grants that mercury and chronic gonorrhœa may produce the process, though he denies all other local causes. Sporadic cases are in his opinion of reflex origin from internal organs and occur chiefly in women. Auto-infection, when toxic substances from internal diseases enter into the blood, and primary instability of the vaso-motor centers are also mentioned as important causes. No dermatologist in America can, however, agree with him that mode of life, food, drink, etc., are not also factors. The very material changes in these regards which immigrants undergo in this country have led not only White to report, but all others to observe, the great frequency with which these individuals suffer from attacks of erythema multiforme. Urticaria pigmentosa receives little attention, and no mention is made of mast-cells in connection with it, though Unna demonstrated the fact so conclusively, and Raymond and Neisser confirmed their important connection with the disease.

Any one familiar with Kaposi's teachings is not surprised to find that he rejects entirely the conception of the dermatitis herpetiformis of Duhring, relegating it to the comprehensive category of pemphigus. His reasons for doing so are certainly not clear, since the disease has come to be recognized by all dermatologists with, I may say, excessively few exceptions, and case after case may be seen which during their entire existence do not present one single bulla. Kaposi recognizes, however, a pemphigus pruriginosus.

In his opinion, erysipelas is not alone due to Fehleisen's streptococcus, but to some other microbe or toxine also, though what they may be he does not say.

Kaposi regards lichen ruber acuminatus and pityriasis rubra pilaris as identical, though since 1889 most grave doubts have been entertained concerning their even remote relationship, and even in Germany their independent positions have been urged by strict followers of the teachings of the Vienna school. We can not but feel that the question becomes only more obscure by the inclusion in the category of lichen ruber of such dermatoses as the "keratosis follicularis" of White and Morrow—cases which are regarded as representatives of Darier's psorospermosis follicularis, which disease Kaposi claims recalls clinically the picture of lichen ruber. He acknowledges, however, that it is clinically "a very important and pathologically a most interesting form of keratosis," and he is in accordance with those who reject the psorosperm nature of the bodies occurring in the disease, regarding them, with Boeck and others, as atypical, transitional, and degenerative forms of the cells.

The chapters on eczema are very full, and deal with its symptomatology, causes, and treatment. As to its causes, he mentions particularly those pro-

duced by external injuries that irritate the skin and produce artificial eczemas, and those which are symptomatic, the result or reflex of a morbid condition of the general organism or of some organ. In the former, almost all possible irritants are included—chemical, mechanical, thermic, etc.—but no mention is made of micro-organisms or of such agents as have led in recent times to the designation of "parasitic eczemas," or those due to the influence of germs. In the symptomatic are mentioned such as come from dyspepsia, diabetes, albuminuria, etc.; in anæmic and chlorotic subjects, neuropathic, etc. He states that eczema is neither contagious nor hereditary, and denies the possibility of a dyscrasia—rachitis, scrofula, etc.—as being in any way a direct cause of eczema. When such is present it merely changes the nutrition of the skin so that other agents—heat, water, etc.—are able to produce the cutaneous disease. Why not, then, micro-organisms also? The treatment of eczema is very full and contrary to the oft-repeated statement that the treatment of the Vienna school is entirely a local one. Kaposi mentions particularly the general and systemic therapeusis. But he very wisely does not state remedies for every systemic disturbance existing with an eczema, but appeals to the common sense of the physician by calling attention to the fact that such disturbances should receive appropriate treatment. There not being any specifics for the internal treatment of an eczema, it being possible for every morbid condition of the general economy to exist in connection with an eczema, and *vice versa*, the relegation by Kaposi of the internal therapeusis to a secondary position, and his statement that the use of internal remedies is to be guided by the symptomatic indications in each case, can not be too highly praised and emphasized. It is so commonly believed and so generally claimed that a cutaneous disease is only the reflection of some internal and systemic disturbance, all other possible causes being left out, that as a rule the therapeutics of the process is limited to this, that, or other medicine poured into the stomach, and a purely negative application is used externally. Such treatment is, of course, only indicative of a want of rational conception of the nature of a process on the skin, and it is therefore particularly valuable to read the general and special therapeutic advice given by Kaposi. It can not but beget in the mind a better conception of the principles of treatment, of its most important features, of the uselessness of devoting one's attention to the accessory factors instead of to those which are primary and determining, and it will enable the medical care of a case to be placed upon a rational and not upon an illusory base.

It is impossible to take up and review every chapter in the book, and, beyond mentioning that Kaposi still adheres to the belief that tuberculosis, as the cause of lupus, is insufficiently proved, I will only state that all the various dermatoses receive such relative attention as is their due. All points of interest are touched upon, the clinical features of each are carefully drawn, and, though many differences of opinion might be pointed out and discussed, yet it is unnecessary to do so here. As a whole, the book is a valuable one, and the English-reading members of the profession are fortunate in its having been made accessible to them. It should, however, be borne in mind that it is essentially a personal book, in so far as it particularly represents Kaposi's individual opinions and views—those which he has now supported and defended for many years. As the work of a most eminent clinician, it can, however, be frankly and warmly recommended to all those who are inter-

ested in dermatology, and they will find it suggesting to them many valuable diagnostic and therapeutic points.

Under the able supervision of Dr. James C. Johnston this book shows an admirable continuity of style, and the translation has been made so well that every line is clear and every sentence devoid of obscurity or of ambiguity. The work which he has expended in attaining this result is to be highly praised. GEORGE T. ELLIOT.

Handbook of the Diagnosis and Treatment of Skin Diseases. By ARTHUR VAN HARLINGEN, M. D. Third edition. Philadelphia: P. Blakiston, Son & Co., 1895.

The work in its earlier editions is familiar to many readers of this JOURNAL who doubtless understand its shortcomings, but for those who are not, it may be said that it is a volume of five hundred and seventy-three pages, "not intended for students of dermatology," devoted to diagnosis and treatment, to the practically absolute exclusion of pathological anatomy and of ætiology, except, in the latter case, such as may be gathered from the symptomatology. The description of the clinical features is often inadequate, as in the articles on lichen planus and sarcoma. Wherein the book's usefulness lies, unless it be in differential diagnosis, is not easily made out, especially when there are other epitomes in English, betraying few of its faults. The fact of its passage into a third edition is the best evidence at hand in its favor.

The arrangement in alphabetical order is not excusable; an index will accomplish as much for ready reference, and the present scheme of classification is good enough for practical purposes. The author insists on the retention of tumors in general semeiology, of ecthyma and lichen ruber among the dermatoses. He accords a place to eczema seborrhoicum, but fails to make clear any demarcation between it and the seborrhœas. Mistakes in Latin grammar, such as lupus sclerosum and tuberculosis verrucosum are too often repeated to be typographical errors. Lichen ruber and lichen planus are inextricably mixed, discussion of the two being confined to two pages, while hypertrichosis, adorned with drawings of museum freaks, is spread over twenty-two. There is no mention anywhere of pityriasis rubra pilaris, even under lichen ruber, none of lipoma, of Raynaud's disease, of hysterical gangrene, of xanthoma diabeticorum, of hidradenitis (this list by no means includes all omissions). The difficulties encountered in diagnosis when the microscope plays no part may be imagined—for example, between fibroma and lipoma. No mention is made of the tubercle bacillus and the importance of its finding in the chapter on tuberculosis cutis. Lupus vulgaris is to be differentiated from syphilis "chiefly by the history of the case in question." The tumors are distinguished macroscopically or not at all. Treatment is incomplete in certain instances: one can hardly comprehend a failure to make some mention of pilocarpine in urticaria. On the other hand, not a few of the articles are worthy of commendation, and are quite as good as could be expected in a work of the size. Among them perhaps the most striking are those on herpetiform dermatitis and the acute exanthems.

It seems quite time that these empirical works, with their shortcomings and inaccuracies, should be displaced by those like Duhring's *Cutaneous Medicine*, "resting on clinical observation based on pathology and pathological anatomy." J. C. J.

Selections.

A New Method of Treatment of Some Infectious Diseases. Dr. Ludwik Rekowski (*Gazeta Lekarska*, No. 3, 1896).

Antitoxine, contained in the blood serum of an animal into which bacterial toxines of diphtheria or tetanus have been injected, are the products of a special irritation of the cell-molecules by the toxines. But this special irritation can be brought about not only by toxines but also by some chemical substances injected or introduced into an animal, and in that supposition lies the explanation of the well-known clinical properties of mercury, salicylate of sodium, and quinine in syphilis, acute rheumatism, and malaria. Acting upon this theory, the author injected into a horse once a week and afterward twice a week 0·3 of the following emulsion of mercury:

℞ Hydrarg. salicyl..... 1·0
Vaselin. liquidi..... 10·0
M. et ft. emulsio.

In the blood serum of the animal very slight traces of mercury could be found.

He injected ten centimetres of the blood serum every three days in the glutei of patients affected with secondary and tertiary symptoms of syphilis, and obtained very gratifying results in a patient with tertiary symptoms, as the gummata disappeared and open sores healed after three or four injections. The same results were obtained by Drs. Hizyn and Wreden (Kiew).

The author gave a horse 0·3 gramme of arsenic *pro die* (45·0 in all). In the blood hardly noticeable traces of arsenic could be discovered. He injected ten centimetres of the blood serum of that horse twice a week into two patients afflicted with cancer of the face, and after six weeks he noticed a remarkable improvement.

The author promises to publish in the very near future more minute details of his method of treatment. Lapowski.

Acne Scrofulosorum in Infants. T. Colcott Fox (*Brit. Journ. of Derm.*, vol. vii, No. 11, p. 341).

The author gives clinical histories of five cases which he classes under this heading, the ages ranging under two years. He states that his first impression was that they were syphilitic, but the idea was abandoned because they failed to respond to antisyphilitic treatment, because the history was problematical, and because the disease never appeared in an undoubted case of inherited lues. The eruption usually disappears under the administration of cod-liver oil and iron. Its clinical features are these: an indolent, small papulo-pustular or acneiform eruption, occurring in infants, sparsely disseminated and not grouped, unaccompanied by subjective symptoms. It affects chiefly the extremities, the lower in particular, and their extensor surfaces. The buttocks and regions above are often involved. The lesions appear successively or by subacute outbreaks. The papules develop about the hair follicles, be-

come successively pustular and crusted. When the crust with a central plug is lost, a flattened, crateriform, irregular lesion, like those of lichen planus, is left. After complete involution, a stain or faint scar remains.

Primary Epithelioma of the Ureter. (Specimens presented by RUNDLE to the London Pathological Society. *Medical Week*, vol. iii, No. 47, p. 549.)

Fullness on the right side existed a year before death, and examination showed a fluid swelling beginning two inches below the liver, extending to the median line and into the lumbar region. Urine clear and freely passed. No symptoms of renal calculus. On tapping, eighty ounces of clear fluid, which had a specific gravity of 1,020 and became nearly solid on boiling, were evacuated. Renal enlargement was diagnosed, and after a time the tumor was again tapped. Death finally resulted from exhaustion. The autopsy showed a large growth in the region of the kidney, beginning in the vesical end of the ureter and spreading into the bladder, seminal vesicles and paravesicular tissues, upward to within an inch of the renal pelvis. The tumor was soft and friable, and was found to be a squamous-celled epithelioma.

Psoriasis Vulgaris in Early Childhood. DR. RILLE (*Wiener med. Wochenschrift*, No. 50, 1895).

Report of a case of psoriasis in a child, five and a half weeks old, observed in the clinic of Prof. Neumann. The eruption was seen by the mother on the fifth or sixth day after birth. Father of the child had psoriasis since the age of twenty. H. G.

Resection of the Vasa Deferentia as a Curative Agent in Hypertrophy of the Prostatic Gland. PROF. DR. HELFERICH (*Deutsche med. Wochenschrift* No. 2, 1896).

The author recommends this operation in place of castration. He resects ten to twelve centimetres of the vasa deferentia, a procedure which is very simple and which can be done without narcosis, even without local anæsthesia. The results in the ten cases thus operated were very satisfactory; viz., the urination was easier, tenesmus less, so that the patients did not have to resort to catheterization. H. G.

A Case of Acute Circumscribed Œdema of the Skin in an Alcoholic Subject. DR. OPPENHEIMER (*Deutsche med. Wochenschrift*, No. 3, 1896).

Report of a case of relapsing angioneurotic œdema, mainly on the face and hands, in a young man, twenty-three years of age, exceedingly obstinate, worse in summer. The author claims that the eruption was due to the use of alcoholics; a relapse was observed after the patient had taken "a couple of glasses of whisky and soda water." The only alcoholic beverage the patient could take with impunity was claret mixed with water. H. G.

A Case of Pyrogallol Intoxication. DR. VOLLMER (*Deutsche med. Wochenschrift*, No. 3, 1896).

A ten-per-cent salve had only once been applied to the forearms of a patient sixty-nine years old with universal psoriasis. His urine had been

examined before and was found free of albumin or sugar. Two hours after the application patient was very much excited, with violent pains in both arms, dermatitis, resembling erysipelas. The salve was washed off immediately. Next day high temperature, albumin in the urine, no hæmaturia. Cure of the dermatitis within a few days, of the albuminuria within two weeks. The author concludes that the nephritis was due to the dermatitis and advises care in the use of pyrogallol. H. G.

Treatment of Acne. DR. BARDACH, of Bad Kreuznach (*Dermatologische Zeitschrift*, vol. ii, No. 2).

The author has not been able to confirm the statements of Barthélemy and Bouchard that acne is nearly always combined with dilatation of the stomach, the latter being the ætiological factor of the skin affection. In sixty-eight cases of acne he did not encounter any cases of dilatation of the stomach. In all cases, however, he found high specific gravity of the urine and an increase of the crystalline sediments. The author therefore concluded that "the increase of the salts in the blood causes an irritation in the sebaceous glands or in their vessels." A quick cure was effected by increasing the diuresis through the "Kreuznach cure." As to the local treatment, Bardach recommends the Kreuznach soap, of which a milder and a stronger one are made, the former containing 1·3 per cent of sodium iodatum and the same amount of sodium bromatum ; the stronger soap being of double strength.

Ueber Intravenoese Injectionen mit Sublimat (Intravenous Injections of Bichloride of Mercury). Von GUIDO BACCELLI, (*Berliner klinische Wochenschrift*, 1894, No. 13).

The author, the well-known Italian physician and statesman, the president of the last International Congress, was the first one who treated malaria by intravenous injections of quinine. Encouraged by the good results which he observed, he employed mercury the same way in the treatment of syphilis. Through numerous experiments on animals he had convinced himself that there was absolutely no danger connected with the new method—*in specie*, that the bichloride of mercury had no injurious effect upon the composition of the blood.

In two severe cases of cerebral syphilis, where all other ways of mercury administration had been tried in vain, the results were excellent. In many clinics in Italy and in private practice the method has been adopted, to the satisfaction of the physicians and patients.

After careful cleansing of the skin, the needle of the syringe is introduced into the cephalic vein or into the one on the surface of the hand or leg after the veins have been brought to better view through bandages applied to the upper arm or femur. The solution is as follows :

Hydrarg. bichlor.	1·0
Natrii chlorat	3·0
Aq. destill	1000·0

One cubic centimetre of this solution is injected daily (equal to one milligramme of bichloride of mercury), and the dose gradually increased to three or four up to eight milligrammes, which is the maximal dose. The injections are painless, and there is no local reaction if properly made. After a

few seconds a salty, and immediately afterward a metallic, taste is experienced by the patient.

The advantages of this new method are, first, the small quantity of the mercury to be employed; second, the possibility to cure symptoms rapidly; third, the prompt and lasting effect of the mercury upon the walls of the blood-vessels, which are very often affected. H. G.

Thioform (*Wiener med. Wochenschr.*, September, 1894).—Steuer uses the dry powder in cases of varicose ulcer, a ten-per-cent. ointment in chancroid and favus, with success. It is described as a dithiosalicylate of bismuth, odorless, insoluble in water, alcohol, and ether; slightly so in alkaline solutions. It is proposed as a substitute for iodoform, being cheaper in use on account of its extreme lightness.

Item.

DR. EDWARD WIGGLESWORTH.

Memorial of the Boston Dermatological Club.—The Boston Dermatological Club desires to express its deep sorrow at the great loss it has sustained in the death of Dr. Edward Wigglesworth, one of its most gifted and accomplished members.

Perhaps no other of the medical societies with which he was connected could so thoroughly appreciate his versatile and brilliant intellect, his warm-hearted nature, and his high attainments in medical knowledge. His contributions to the literature of our specialty were many and valuable in the early part of his active professional life; and although partially disabled by failing health in later years, he has remained an earnest student of the work of his colleagues and of the extensive progress of our art to his last hour.

His interest in this clinical society has been warm and constant since its foundation, and we shall sadly miss his skilled judgment in the solution of difficult questions in diagnosis. His generosity was unceasing, and he has left a permanent memorial of it of great value to students of dermatology in the large collection of the famous Baretta models of cutaneous diseases, presented by him some years ago to the Medical School of Harvard University.

The loss of such an accomplished physician in the maturity of his wisdom is a serious one to the profession and the community.

To his family we offer our sincerest sympathy in their bereavement.

BOSTON, *January 28, 1896.*

JOURNAL OF
CUTANEOUS AND GENITO-URINARY
DISEASES.

Vol. XIV. APRIL, 1896. No. 4.

Original Communications.

NOTES ON SYPHILIS.—SYPHILOMA OF THE NOSE OF UNUSUAL FORM AND EVOLUTION. THE DIAGNOSTIC VALUE OF SYPHILITIC CICATRICES. EXTRA-GENITAL CHANCRES, PROGNOSTIC SIGNIFICANCE OF. PROFESSIONAL SYPHILIS.

By PRINCE A. MORROW, M. D.,

Surgeon to the City Hospital; Attending Physician to the New York Hospital, Department of Skin and Venereal Diseases.

I. Syphiloma of the Nose of Unusual Form and Evolution.

THE patient with the lesions portrayed in Fig. 1 presented herself at the New York Hospital, May, 1894, with the following history: She was twenty-one years old, had been married five years. The first child, three years and ten months old, is healthy; the second died when about a month old; the third pregnancy resulted in a miscarriage. After the miscarriage the mother suffered from sores in the mouth and throat, with a generalized eruption of reddish spots. The scalp was so profusely studded with sores that she was compelled to cut off the hair. There has been no marked alopecia of the scalp, but the eyebrows and eyelashes were entirely lost. The eruption disappeared in about three months.

In October, 1893, an eruption of large tumors appeared over various parts of the body, many of which have undergone involution, leaving scars. These tumors have continued to appear since. At the present time there may be seen upon the arms a number of nut-sized globular tumors springing up from the skin like mushrooms and strikingly suggestive of the tumors of granuloma fungoides. The tumors

are doughy in consistence, but not suppurative. The external aspect of the lower part of the right os humerus is occupied by five or six tumors surrounded by interrupted circles. On the right upper arm are seen tumors which have developed in cicatricial areas which mark



FIG. 1.

the site of former lesions. A cherry-sized gumma occupies the inner border of the left eyebrow. The tumor is soft, painless, and adherent to the skin.

The most interesting feature of this case, however, is the large, tumorlike infiltration which occupies the upper lip, blocking the aperture of the left nostril, and mounting upward on the left ala to the bony and cartilaginous junction. This infiltration does not extend upon the cheek, and is sharply demarcated from the healthy skin. The mass is surmounted and circumscribed above by a large, weltlike ring of infiltration which is exceedingly dense and hard to the feel. The lower part of the tumor is less resistant and softer in consistence. Under the influence of mixed treatment the tumors upon the arms and left eyebrow underwent rapid involution, but the lesion of the nose and lip was scarcely modified, although the constitutional treatment was re-enforced by the application of ung. hydrarg. and mercurial plaster.

So peculiar was this lesion in its form and consistence and so refractory to specific treatment, that a suspicion of its representing a combination of syphilis and tuberculosis was entertained. The patient was presented before the New York Dermatological Society. Some of the members thought that there was probably a tuberculous element present, and suggested the removal of a piece, to be examined for tubercle bacilli. This proposition was not acceptable to the patient, and she ceased her visits. I afterward learned that later she went to the Vanderbilt Clinic, and after some weeks of specific treatment the tumorlike mass on the side of the nose softened, broke down, and disappeared. I examined the patient January 29, 1896, and found that there was some infiltration of the upper lip, which, she states, becomes swollen and enlarged at each menstrual period. The left ala is somewhat contracted, showing at two or three points slight loss of substance.

II. Diagnostic Value of Syphilitic Cicatrices.

Syphilis possesses the peculiarity not only of manifesting itself during its active stage by lesions which are typical and characteristic, but also of leaving indelible traces of its action upon the cutaneous surface in the shape of cicatrices. Another peculiarity of syphilis is its mysterious uncertainty. No matter how mild or malignant its past, there is always the possibility of a formidable future. Long after the fires of the disease have apparently burned out, revealing in the scarred tissues the nature of the destructive process that has swept over them, they may break out anew upon the surface or be rekindled in some important central organ. So profound and permanent are the changes in the tissues wrought by syphilis that the exhumed bones of prehis-

toric sepultures may preserve positive evidences of their syphilitic origin and nature.

While the imprints of syphilis upon the cutaneous surface are not always so typical as to enable even the most practiced observer to decipher the nature of the process which has produced them, yet in many cases they have a positive value as a retrospective aid in diagnosis. It is not intended to assert that the cicatricial remains of syphilitic ulceration present characters which are absolutely distinctive. Syphilitic scars taken singly may be exactly imitated by the scar following a burn, a traumatism, or the ulcerous process of some other disease. But when they are multiple, when they exhibit certain specific peculiarities in their circular or serpiginous outline, their grouping, their pigmentation, their localization, they may be just as characteristic of syphilis as were the lesions in their full stage of activity.

Lupus or cutaneous tuberculosis may produce scars similar to those of syphilis, but they are distinguished by their limitation to certain regions and by their minute characters. The scars of tuberculosis are irregular, uneven, and vicious, with a more livid pigmentation. The cicatrices of varicose ulcers of the leg may imitate closely those of syphilis in this locality, but they are generally limited to the lower third of the leg, while those of syphilis most often occupy the middle and upper third. The pigmentation of the former is more diffuse and permanent, often spreading over one half or more of the limb, while the pigmentation of syphilis almost invariably clears up, leaving white scars. The scars of zoster may be multiple and indistinguishable in their appearance from those of the small tubercular syphiloderm, but they are differentiated by their asymmetry and their localization along the course of certain nerves.

In the picture presented in Fig. 2 we have an example of scars which are typical of syphilis, not only in their minute objective characters, but in their localization and general distribution. They are rounded or circular, more or less depressed, according to the depth of the ulcerative process, the older ones white, with a vanishing zone of pigmentation, the more recent ones red, encircled with a dark-brown, almost black area of pigmentation. These vestiges or marks of an antecedent syphilitic ulceration are typical and will remain so during the lifetime of their bearer. Such stigmata would be of great value in the diagnosis of any obscure nervous or visceral complication in the future.

All specialists are accustomed to have referred to them cases in which it is extremely difficult to differentiate between the late manifestations of syphilis and other diseases. The late surface lesions of

syphilis may in most instances be diagnosticated by their optical characters; the same is true of affections of the mouth, tongue, and throat.

Lesions of the testicle, bones, and joints may also often be distin-

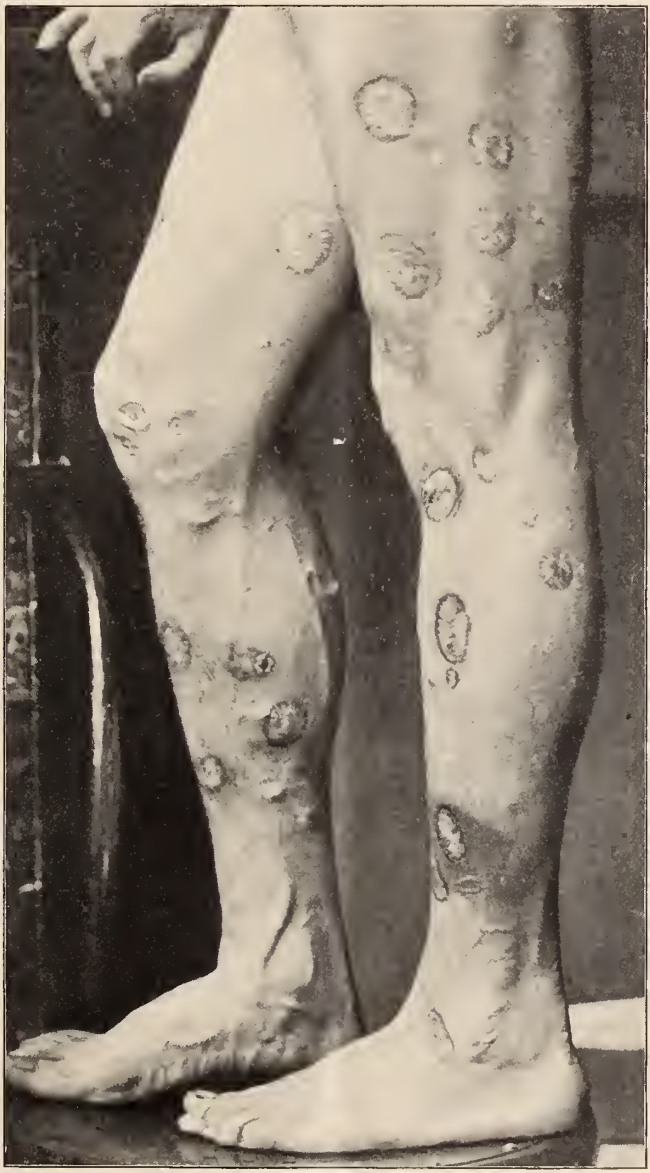


Fig. 2.

guished by objective characters peculiar to syphilis, but in the presence of syphilitic affections of the internal organs, and especially in obscure diseases of the nervous system, the symptoms do not differ essentially from the symptoms of other diseases affecting these organs. Any sign which would lead to the identification of syphilis as the ætiological factor in such cases is of the utmost importance. While recognizing the value of the patient's history in throwing light upon the nature of obscure affections, we find that many syphilitics are unwilling to own up to an avowal which they consider an impeachment of their morals and respectability. They will fence with the examiner, and, in answering questions, conveniently forget any circumstance which might indicate the syphilitic origin of their trouble. Especially is this the case with women. In such cases the discovery of characteristic syphilitic scars may furnish the connecting link between doubtful symptoms and syphilis. Such a discovery is most fortunate for the patient, as, thanks to the wonderful efficacy of specific treatment, it carries with it in many cases an almost certain assurance of cure.

III. EXTRA-GENITAL CHANCRES.

During the past three years twenty cases of extra-genital chancre have occurred in my public practice. Fifteen of these cases came under my observation at the New York Hospital, and five were seen in my service in the City Hospital.

In my private practice within the same period ten physicians have consulted me for chancres of the hand or fingers contracted in the exercise of their professional work. To speak with absolute accuracy, only nine of these were seen by me; the tenth came to consult me last summer, during my absence from the city, and was seen by my assistant, Dr. Johnston, who took notes of the case.

I am well aware that extra-genital chancres are by no means rare in the practice of specialists. My object in reporting these cases is not to illustrate new and interesting clinical features, but simply to utilize them as a basis for certain deductions of practical importance. The clinical appearances and course of extra-genital chancres are so familiar that a detailed description of each individual case is unnecessary. Certain points in relation to their location and ætiology may, however, be of interest. In the twenty cases seen in public practice there were:

Chancres of the upper lip	3
" " lower lip	5
" " chin	3
" " gum	1

Chancres of the tongue		1
"	" hard palate	1
"	" soft palate	1
"	" pharynx	1
"	" cheek	1
"	" fingers	2
"	" anus	1

It will be seen that this series embraces seventeen cephalic chancres, two digital, and one of the anus.

The *chancre of the hard palate* merits especial mention, from the exceeding rarity of the initial lesion in this location. It was deemed of sufficient interest to present the patient before the New York Dermatological Society. In this case the lesion was situated to the left of the median line, and presented the appearance of an ulcerated gumma. The submaxillary glands of the left side were enormously tumefied, obliterating the lines between the jaw and the neck. Any possible doubt as to the nature of the lesion was removed by the appearance of a maculo-papular eruption six weeks after the sore. Concerning the mode of infection no definite information could be gained.

The *chancre of the gum* may also be noted for its comparative rarity. It was situated on the right of the median line, and occupied a surface corresponding to the lateral incisor, the canine, and bicuspid teeth. It presented the appearance of a semilunar erosion of the gum, which was red and slightly tumefied. The epithelium was detached from the center. The chancre did not heal until after the appearance of secondary accidents. In attempting to trace the ætiology of the disease, the patient absolutely denied any lascivious contact. He was a barkeeper by occupation, and ascribed the contagion to a rather curious cause. He was accustomed to use his mouth as a receptacle for the coins which he took from customers until he found it convenient to deposit them in the cash drawer, and he thought himself infected by this means.

In another case—*chancre of the tongue*—curiously enough, the contagion was ascribed to paper money. The patient, a young woman twenty-six years old, presented herself at the New York Hospital with a corneous syphilide of the palms and a general papular eruption. She denied most indignantly that she had exposed herself to contagion in the usual way, and her claim of virginity was confirmed by an examination. There was no trace of enlarged glands in the groin. She stated that her occupation as cashier in a large establishment required her to count a great deal of currency every evening. In counting over the rolls of bills she was accustomed to moisten her finger by placing

it on the right side of the tongue. Some three or four months ago she observed that this part of the tongue became quite sore, so that she had to moisten her finger by touching the tip of the tongue. The side of the tongue continued sore, and soon afterward the glands of the right side became enlarged, followed later by patches on the tonsils and an eruption on the cutaneous surface. Examination disclosed on the side of the tongue at the point she indicated a slight cicatricial depression, which in all probability marked the site of the initial lesion. The most minute examination failed to discover any other probable seat of the chancre.



FIG. 3.

One of the three cases of *chancre of the chin* was distinguished by its enormous dimensions. It occupied nearly the entire surface of the chin, extending from the edge of the lip to the mental border. The surface was ulcerated, the edges elevated, hard, and everted, presenting the appearance of an ulcerated epithelioma. As a matter of fact, the patient's physician had made this diagnosis, and he had been sent to the New York Hospital to have the "cancer cut out." Before operating, the house surgeon referred the case to me for an opinion. The diagnosis of epithelioma was contraindicated by the age of the patient, the optical features of the lesion, its rapid development, and the precocious implication of the glands. Any possible doubt as to its specific nature was set at rest by the appearance of a macular eruption on the chest and other signs of constitutional syphilis. Notwithstanding the enormous volume of the lesion, there was scarcely any appreciable cicatrix left after its involution.

One of the cases of *chancre of the upper lip* was also remarkable for its elephantine proportions. The entire upper lip was enormously tumefied, everted, with a fungating, easily bleeding surface. The

inflammatory induration was so marked as to almost completely immobilize the lip. The other lip chancres presented nothing in their appearance or mode of evolution to call for special description. The ætiology was variously referred to kissing, contact with pipes, etc. In one case a chancre of the lower lip in an infant had been contracted from a syphilitic nurse.

The *chancre of the anus* was the result of unnatural practices, to which the patient confessed. The chancre over the *malar portion of the left cheek* was the result of a blow received in a fight with a drunken man. The cases of *chancre of the finger*, both of which were seen in the City Hospital, were ascribed to bites received in drunken brawls. In one of these cases, some months after the chancres had healed, the entire integument of the index finger presented a dusky-red appearance.

In this connection I may present the picture of a chancre over the knuckle of the right hand (Fig. 3) sent to me by the late Dr. E. R. Palmer. It resulted from a blow which the patient administered to a drunken tramp. The skin was broken by the force of the blow. A few weeks afterward the lesion depicted appeared, and was followed by a characteristic eruption.

In the ten cases of professional syphilis the location of the chancres was as follows:

Chancre of terminal phalanx of index finger	5
" " " middle finger	1
" " " little finger	1
" " " thumb	1
" distal extremity of first metacarpal bone	1
" outer border of wrist	1

As regards the location of chancres of the hand and fingers, Fournier's statistics, embracing eighty-eight cases, give only one case of chancre of the wrist, while the thumb and the little finger were only very exceptionally its seat. Chancre of the middle finger, according to Fournier, is most often the result of contamination in venereal dalliance.

In none of these eight cases of digital chancre was the lesion hypertrophic or fungating. Two of them were examples of the panaris type, while the others were of the superficial erosive or slightly ulcerous type, with a brownish or dusky-red elevated and indurated base. The accompanying picture (Fig. 4) of chancre of the forefinger in one of these cases was taken after the lesion was in process of healing. All were accompanied with epitrochlear and axillary adenopathy, with

one exception. In this case I could not detect the slightest trace of glandular enlargement. To be clear upon this point, I wrote to the patient recently, who replied: "I have never had an enlarged gland; the only symptoms of syphilis I have had were the first eruption and the throat lesions a year later, which you saw and treated."



FIG. 4.

In regard to the ætiology of these cases, seven ascribed their infection to digital examinations or manipulation in obstetrical or gynæcological work; three, to contamination in the course of surgical work. Two of the latter were infected at the same time in performing a perineal section in a syphilitic patient—the operator through a hangnail on the little finger; his assistant by an accidental prick on the wrist by the knife used in making the section. Some weeks later the operator, alarmed by the long persistence of the sore on his little finger, came to consult me as to its nature. In the absence of any glandular enlargement, I gave a tentative diagnosis of syphilis, which was confirmed ten days later by the appearance of a characteristic eruption. Some two

weeks afterward the surgeon who had assisted at the operation came to consult me. The chancre on the wrist had practically healed, but there was a generalized papular eruption.

As before intimated, these cases are presented not so much for their intrinsic interest as a basis for some general reflections.

The Prognostic Significance of Extra-genital Chancres.—As is well known, there is a tradition or belief in the profession that extra-genital chancres are not only more apt to be severe in their local processes, but more liable to be followed by a grave syphilis. Chancres of the fingers, especially, are thought to portend a bad type of syphilis. As the French phrase it, "It is a misfortune for a man to catch the pox; it is a much greater misfortune for him to take it in any other way than by the genital way." This conception that the gravity of a constitutional infection may be modified by the seat of inoculation receives support, it is claimed, from analogy with other infectious diseases. Thus, for example, there has been observed a marked difference in the relative mortality of mad-dog bites according to the region in which the virus is implanted. The mortality of rabies is four times greater from wounds of the face and neck than from wounds of the lower extremities. This difference may, however, be explained partly on the ground that as the lower members are habitually clothed, the virus is often absorbed by the clothing, while the richer lymphatic and vascular supply of the face furnishes more favorable conditions for successful inoculation. In the case of syphilis, however, it is difficult to believe that the constitutional effects of the syphilitic virus are materially modified by its port of entry into the system. So far as the *local effects* are concerned, we can readily understand why their severity may be influenced by the accident of location.

Chancres of the fingers, especially those of the panaris type, are proverbially painful and apt to be attended with severe glandular complications. The pain is readily explicable from the character of the tissues involved, the structures being compact, dense, and resisting, and the nail bed endowed with the most exquisite sensibility. Sympathetic irritation, no doubt, enters as a factor in the production of adenitis. Again, the digital chancre is subject to numberless causes of irritation from pressure, painful contacts, and knocks, etc., besides being exposed to secondary infection from pyogenic germs; the septic process thus set up is not infrequently attended with severe lymphangitis, pyæmia, and other complications.

Likewise, chancres of the lips, tongue, and pharynx are exposed to multitudinous causes of irritation from contact with food, spices, hot liquids, etc., while the constant movement of the parts in talking and

swallowing interferes with the rest necessary to prompt healing. Chancres of the tonsil especially have a bad reputation. The structure of the tonsil is favorable to syphilitic infiltration, while its crypts and anfractuosities constitute favorable breeding places for pyogenic cocci. The malaise, fever, and other signs of constitutional disturbance are doubtless due, in many cases, to secondary infection. Some time ago I had a case of chancre of the tonsil in private practice which had been previously treated for four weeks as a case of diphtheria under the care of two physicians and a trained nurse. The identical aspect of the false membrane of chancre of the tonsil with that of diphtheria would extenuate but not excuse the mistake in diagnosis.

As regards the local process, it may be conceded that extra-genital chancres are more apt to be severe, but this increased severity is due to peculiarities of anatomical structure of the parts and local causes of irritation. But, advancing a step further, do we find that the accident of location influences the ulterior evolution of the disease—in other words, is syphilis contracted extra-genitally more grave in type than syphilis received in the ordinary way?

So far as my observation of these cases would throw any light upon the determination of this question, it must be answered in the negative. In none of them was the gravity of the resulting syphilis more pronounced than in the average run of patients. Of the dispensary cases the majority have been under my observation for variable periods—some of them constantly for more than two years. Most of them have attended with the intermittent regularity which characterizes patients of the dispensary class; they would continue to come until the disappearence of existing accidents, and then cease their visits until the recurrence of another outbreak of symptoms.

Of the ten physicians who figure in the above category, four still continue under my personal care; two of them, who live at a distance, I hear of from time to time; the remaining four passed from my observation as soon as the diagnosis was definitely established. Notwithstanding the fact that physicians are notoriously bad patients, in all these six cases the constitutional symptoms have thus far been of mild or medium severity.

It is evident, however, that conclusions based upon the observation of syphilis during the secondary stage have a comparative rather than an absolute value, because, except in malignant precocious syphilis, the elements of gravity are only manifest at a later stage.

This question has been studied by Prof. Fournier in his usual careful and scientific manner. In a recent lecture upon the "Comparative Gravity of Extra-genital and Genital Chancres," he has analyzed a

large number of personal statistics, covering long periods, which directly bear upon the determination of this question. Starting with the general proposition that statistics of ten thousand cases of chancre show that ninety-three per cent are genital and seven per cent are extra-genital, he has considered the criteria upon which the gravity of syphilis may be based.

1. *The occurrence of tertiary accidents* he regards as one of the best criteria of the gravity of syphilis. In twelve hundred cases of tertiary syphilis he found that in six or seven per cent it originated in extra-genital chancres, and in ninety-three to ninety-four per cent it had for its point of departure genital chancres. The second criterion is *the occurrence of*

2. *Malignant precocious syphilis.* In two hundred and forty-two cases of malignant precocious syphilis genital chancres were responsible for ninety-two per cent, and extra-genital chancres for seven per cent of the cases.

3. *The occurrence of cerebral syphilis*, which is accepted as the most formidable accident of syphilis, he takes as the third criterion of gravity. In seven hundred and seven cases of cerebral syphilis ninety-five per cent made their *début* by genital chancres, and only five per cent resulted from extra-genital chancres. These statistics, which were taken impartially without knowing where they would lead, would seem to prove that so far as cerebral syphilis is concerned it would more likely result from a genital than an extra-genital chancre.

Notwithstanding these statistics, Fournier still insists that the digital chancre is grave, not because of its location but because of the soil in which it generally develops. It occurs, as a rule, upon the physician who is generally run down and fatigued. The moral effect is, moreover, depressing, since the physician, knowing the dangers of the disease, lives in a state of great anxiety. Finally, physicians do not take care of themselves. Some have a therapeutic skepticism, some treat themselves, while others consult a great number of their *confrères*, and continually change their medication.

Upon this point the opinion of another distinguished authority may be quoted. Mauriac, in his recent work (1895) on the Treatment of Syphilis, says: "Chancres of the fingers have a bad reputation, and it is merited. In the first place, they are often grave in themselves, especially when they are large, ulcerated, and fungous, and when they become complicated with an inflammatory panaris, with pain, necrosis, etc. But they are especially dangerous and almost impressed with malignity in their consequences as to general infection.

All authorities are united upon this point. It is incontestable that syphilis from a digital chancre is a dangerous syphilis, and turns easily to tertiarism. This fact is difficult to explain."

PROFESSIONAL SYPHILIS.

Without further discussing this aspect of the question, it may be said that chancres of the fingers possess a peculiar interest for physicians, who from their occupation are most exposed to contract syphilis through this medium. While medical men can not claim an exclusive monopoly of digital chancres, yet they are immeasurably more common among accoucheurs and surgeons. In Fournier's statistics of forty-nine cases, thirty occurred in physicians. These facts emphasize the following points:

1. *The Personal Risks of the Physician.*—Medical men, especially those engaged in obstetrical and surgical work, can not be too strongly impressed with a recognition of the risks incurred. Professional syphilis is much more common than is generally supposed, and for obvious reasons. Syphilis is not a disease which reflects credit upon its possessor, and the unfortunate victim is not eager to proclaim himself a syphilitic. On the contrary, he is disposed to carefully conceal the nature of his disease, not only from motives of delicacy, but because of the injury to his professional interests which a knowledge of the fact would carry with it. In years past I have seen a great number of cases of professional syphilis, and know of at least two recent cases among my colleagues of the City Hospital which have not been included in the above category. Forewarned is forearmed, and the recognition of the danger would lead to greater care in the protection of the fingers, and greater circumspection, not only in the examination of known syphilitics, but of patients of whose history and antecedents nothing is known. It is a noteworthy fact that specialists in venereal diseases who are most exposed to constant contact with syphilis are rarely contaminated. This is because they recognize the danger and take greater precautions to guard against infection.

2. *The Risk to Others.*—The important fact must not be lost sight of that the dangers of professional syphilis are not purely personal; they are not to be measured alone by the risks of contagion to the patient's family and intimates. A digital chancre involves serious danger to those with whom its bearer comes into professional relations. The many well-attested local epidemics of syphilis which have originated from a chancre on the finger of an accoucheur, besides numerous scattered cases where one or more women, and through them their families, have been contaminated in the same way, furnish a large

contingent of cases in the literature of syphilis insontium. I might refer to the historical epidemic of St. Euphémie, originating from a chancre on the finger of a midwife, where fifty women were the immediate victims; to the epidemic of Brives (1874), reported by Bardinet, when thirty-one cases of syphilis, with four deaths, were traced to a midwifery chancre, etc. Enough has been said to show that a chancre on the hand of any one engaged in obstetrical work may be a prolific cause of syphilitic infection.

These facts suggest an ethical question of great practical importance, viz., whether a physician is justified in continuing his professional work while he bears upon his hands such an active source of contagion. The surgeon, or the physician in general practice, may be able to render himself innocuous to his patients by a suitable protective dressing—such as a rubber stall, for example. Where the chancre is inflamed and very painful, the pressure of such an appliance would render its use impossible. So far as the accoucheur is concerned, there can be no doubt as to his manifest obligation to discontinue his work until the chancre is healed. The fact that he can ill afford to give up his work during this long period does not affect the moral aspect of the question. One of the physicians who came to consult me had a very large obstetrical practice in this city, and he had continued to attend to his work for several weeks after the chancre appeared. To my question as to how many women he had exposed to possible contagion during this period he was unwilling to reply. He assured me, however, that not even a suspicion of the syphilitic nature of the sore had crossed his mind until the eruption appeared. This brings us to the consideration of

3. *The Importance of an Early Diagnosis of the Digital Chancre.*—I have been more than once surprised at the invincible repugnance on the part of the bearer of such a lesion to recognize its true nature. Almost all of them maintain that it must be a simple sore, a felon, a septic infection, or something else, and they cherish this delusion until their perceptions are quickened by the appearance of unmistakable constitutional symptoms. One of my patients, acting on the advice of his *confrères*, that his chancre was an infected wound, had it scraped and cauterized, and the entire chain of glands, including the axillary, extirpated. This procedure delayed somewhat, but did not prevent, the evolution of the disease. A more general recognition of the frequency of this mode of infection on the part of the profession would more readily awaken suspicion as to the possible syphilitic character of any suspicious sore which develops on the fingers. In fact, it would be a safe rule for any physician bearing upon his hand or fingers an

indolent ulcer, which in its appearance and sluggish evolution does not correspond to ordinary lesions in this locality, to at once suspect its possible syphilitic nature.

4. The *prophylactic precepts* which the study of these facts impose are to preserve intact, as far as possible, the integrity of the epidermis of the hands and fingers, and to use great circumspection in making vaginal examinations, and in operations on syphilitic subjects. Observation shows that digital chancres are most often contracted from mucous patches of the vulva, or from masked or concealed lesions in persons not known to be syphilitic. Many physicians, called to a woman in labor, are accustomed to make a digital examination without inspection of the genital parts, or without any knowledge of the condition of the patient's health.

So far as we know, a sound and unbroken epidermis affords a perfect safeguard against inoculation. Cuts, pricks, abrasions, fissures, hangnails, eczematous eruptions—any break of the epidermis from whatever cause—may be a port of entry for the syphilitic virus. Lesions of continuity may be so microscopic as to escape ocular detection, but exposure of the hands to the vapor of ammonia may reveal the existence of unsuspected breaks in the epidermis. It is hardly necessary to insist that the hands should be thoroughly washed immediately after examination of any syphilitic, whether they come in contact with syphilitic lesions or not. For this purpose the free use of soap and hot water is better than the strong mercurial or carbolic washes employed by many surgeons. As a matter of fact, the latter often cause a chapped condition of the skin, thus affording a favorable surface for inoculation. Moreover, the free use of sublimate or other aseptic washes immediately after contact with the secretions or blood of a syphilitic is deceptive as a prophylactic against inoculation. Jullien reports the case of a medical man who was called upon to examine a sore on the glans penis of a patient. He carefully lifted up the organ between the thumb and index finger, but in doing so his middle finger, upon which there was an abrasion, accidentally came in contact with a mucous patch of the scrotum which had not been observed. The contact was but momentary and the part was immediately washed in a strong antiseptic solution; nevertheless, a chancre developed on the finger, followed by severe constitutional infection.

AN UNUSUAL CASE OF NÆVUS UNIUS LATERIS.

By CHARLES C. RANSOM, M. D.,
New York.

PATIENT, B. M., female, aged twenty, is a native of Germany, although she has lived in this country since early childhood. The general health has always been good, although she is rather thin, and of a nervous temperament.

At birth the skin was perfectly smooth, and free from eruption of any kind. When about six months of age small areas of warty growths appeared on the chest and left side of the neck. These gradually and very slowly spread until puberty, when for a couple of years their growth was rapid. Since the fifteenth year the patches have not spread to any extent, but have grown darker and much more pronounced.

The eruption consists of various-sized and irregularly shaped patches, made up of slightly elevated growths, brown or black in color, distributed from the border of the scalp to the upper portion of the calves, and for the most part upon the left side of the body.

The most prominent patches consist of numerous isolated warty growths, closely aggregated, and distributed for the most part in the form of vertical lines or bands.

On the forehead, in the border of the hair, more especially on the right side, are numbers of very small, slightly elevated warty growths, isolated and scattered over the entire region. These are so light in color as to be scarcely perceptible except on close scrutiny. They extend down over the left cheek, and are scattered over the eyelid and ear on this side.

Over the left side of the chin are aggregated patches of the growths, the color being that of the normal integument; from these patches four or five strings of individual lesions extend down underneath the chin and on to the neck.

The neck is covered in front, on both sides of the median line, with similar isolated growths, which at the lower segment tend to become aggregated and are darker in color.

At the upper border of the sternum are several patches of closely aggregated light-brown growths, which extend in bands of the same character down over the sternum to the ensiform cartilage, at which point is a large irregularly shaped patch.

Over the left side of the chest, anteriorly, are large patches made

up of an aggregation of these vertical bands, together with isolated lesions.

The entire left breast, with the exception of a small segment on its



FIG. 1.

lower side, and including the nipple, is covered by a dark-brown patch of the growths, so closely packed as to leave no normal skin visible.

This patch extends in a band three inches wide up into the left axilla, the lower border becoming continuous with a band which extends around the side to meet a patch in the back, the upper border ending in a patch of large-sized, darker-colored lesions situated at the border of the hair in the axillary space (Fig. 1). Here the growths are nearly black in color, the individual lesions much larger and more papillomatous in character. From the excessive sweating in this region the growths are often macerated, and give rise to a great deal of discomfort.

From the upper part of the breast other narrower bands extend up over the face of the shoulder and encircle the axilla anteriorly, being continuous with a bandlike patch which extends down the arm. On the right side of the chest are numerous more or less isolated lesions, lighter in color than the preceding, and extending outward in an irregular band to the anterior border of the right axilla, which it encircles as on the other side, and becomes continuous with a band extending down the right arm.

From both axillæ, but more marked on the left side, band-shaped patches extend down the inner side of the arm to the bend of the elbow, and on the left arm from the elbow to the wrist.

Over the left shoulder are numerous small groups and many individual lesions, light brown in color. From the shoulder small light-colored bands extend down the external aspect of the arm to the elbow.

On the right side is a large irregular patch in front, and numerous scattered individual lesions behind.

In the median line, over the epigastric region, is a string of dark-brown individual lesions extending nearly to the umbilicus. Over the left inguinal region are scattered a few light-brown isolated lesions.

In the left groin are several small groups of large, dark-colored growths extending down on the thigh in broken lines.

On the inner side of the thigh is a large patch of closely aggregated blackish growths of large size. On the integument of the left labium major is a patch extending down on to the thigh. Those covering the labium are similar in appearance to the ones in the left axilla. From this patch bands of growths extend down the inner side of the thigh to the knee. From the inner border of the left popliteal space two strings of lesions extend down on to the calf.

On the back, in the infrascapular region, and just to the left of the median line, are several irregular patches of large, dark-colored lesions, closely aggregated; from these, similar patches extend out over the scapula to the point of the shoulder, thence down the arm to the elbow.

Below this patch, and beginning to the left of the median line, is another similar patch, which extends outward across the lower border



FIG. 2.

of the scapula to join the lower border of the band coming from the breast (Fig. 2).

A third patch, very dark and irregular in outline, is situated below

this one over the spinal ends of the tenth, eleventh, and twelfth ribs. Over both sides of the median line, in the lower lumbar region, are scattered several small patches. Over the right sacro-iliac junction is a small irregular patch, and another is situated over the right side of the coccyx.

A large group of scattered lesions over the middle of the left buttock extends in numerous lines out across the thigh and down its anterior surface.



Fig. 3.— × 75. (Photomicrograph by Dr. J. A. Fordyce.) Section of one of the warty growths, showing the hypertrophy of the epidermis.

There never have been any subjective symptoms connected with these growths, except in the case of those in the left axilla, as above mentioned, but the disfigurement of the body is distressing to the patient.

The photomicrograph (Fig. 3) shows the irregular development of the epidermis; all the layers have undergone hypertrophy. The ab-

normal formation of horny tissue can be readily seen in a number of places in the illustration. The basal layer of the epidermis is deeply pigmented, and the connective tissue of the derma presents a uniform light-brown color under the microscope.

She came to me to see if they could not in some way be removed. I tried various methods of removing the growths: curetting with and without the use of chromic acid; afterward electrolysis, the galvano-cautery, the application of nitric, acetic, or chromic acids; but the most satisfactory procedure, both from the patient's standpoint of comfort and in the results obtained, was the use of a flat-pointed scissors. The skin was picked up between the thumb and fingers, and the top of the ridge so made was snipped off, the cut being superficial and extending not quite through the skin proper.

INTERESTING POINTS CONNECTED WITH A NEPHRECTOMY SECONDARY TO A NEPHROTOMY.*

BY EUGENE FULLER, M. D.,
New York.

THE following case was referred to me as one of probable prostatic hypertrophy. As a cure for all his ills he had been urged to accept castration, but, happily for him, he had refused to follow that advice. His subjective symptoms so closely simulated those frequently produced by prostatic senile hypertrophy that he had run the gantlet of numerous metropolitan hospitals without apparently awakening in any surgical mind a suspicion that his case was one of kidney, pure and simple.

In effecting a cure in this instance I was forcibly struck by the advantages which, as Israel has pointed out, pertain to a nephrectomy with temporary drainage, followed after a short interval by an extirpation of the organ. By his statistics Israel has shown that a suppurative and distended kidney can in this manner be removed with less mortality than by a primary nephrectomy. The reasons for this decrease in the death-rate in such cases, it seems to me, are chiefly threefold and capable of being grouped under the following headings: First, if the renal pelvis is thoroughly drained, and if all collections of

* Read at the February, 1896, meeting of the Genito-Urinary Section of the New York Academy of Medicine.

pus situated in the renal substance are made to connect with it, the circumference of the kidney will be greatly reduced in size, and consequently the organ can be removed more easily and through a smaller incision than otherwise. Second, as a result of the nephrotomy and the disturbance to which it necessarily subjects the kidney, sufficient plastic lymph is thrown out about that organ and along the track of the incision to, in large measure, protect the system on the occasion of a subsequent nephrectomy from the absorption of the bacteria and purulent material necessarily associated with a suppurative pyelitis. Third, after a nephrotomy and drainage through the loin, the functional status of the remaining kidney can be accurately studied and ascertained. Consequently, of course, a secondary nephrectomy would naturally be undertaken only in such instances as show the remaining kidney to be fairly sound.

The preceding surgical method is advocated for cases in which the suppurative process is confined to the kidney itself. If the perirenal structures have become involved, then the reasons just enumerated in favor of a nephrectomy secondary to a nephrotomy may no longer exist, and a primary nephrectomy may be preferable. The following is a history of the case.

Mr. T., fifty-nine years old, married, had enjoyed good health until eight years ago. At that time he was seized, without any apparent previous history of difficulty in urination, with complete retention. He then entered a hospital with a very distended bladder. A catheter was introduced and his urine drawn off. He had considerable fever following this attack. He remained in the hospital six weeks. After catheterization for a short interval his bladder resumed its function. Since that attack, however, he had never been really well, and his act of urination had always been uncertain. Sometimes for a considerable interval, especially in hot weather, he had been able to urinate satisfactorily and at proper intervals; but in cold, damp weather, or after any overexertion, the urinary act would become urgent and his stream small, and then if he did not speedily take to his bed retention would result. At such times also he had been subject to chills and fever. When seized by a severe attack he had generally entered a hospital. His urethra had been stretched with sounds many times, and his bladder had been frequently searched and washed. All such treatment, however, had either been barren as regards results, or else had aggravated his symptoms. When I first saw him, about four months ago, he was suffering from what he considered a mild one of his attacks. His temperature was between 100° and 101°. He urinated with great difficulty, and there existed considerable tenesmus. His urine was

purulent, somewhat offensive to the smell, acid, and albuminous to the extent of one per cent by weight. It contained no casts, no bladder epithelia, and no typical renal epithelia, but much granular material and detritus. The finger in the rectum showed nothing abnormal aside from a rather rigid condition of the prostatic body and of the tissues constituting the vesical neck, but with the history of frequent instrumentation for many years such a feel, it seemed to me, would naturally be expected. I then had him urinate, and after the completion of the act I slipped in a catheter, only to find the bladder completely empty. A further search of the urethra and bladder failed also to reveal any disease aside, perhaps, from a moderate degree of vesical atony. On abdominal palpation I found much muscular rigidity, especially upon the right side. I administered chloroform, and even under complete anæsthesia sufficient rigidity persisted on the right side to prevent my feeling the kidney. On the left side, however, everything was relaxed and the kidney appeared normal. Although from my examination I felt quite positive that his trouble lay in the right kidney, still I had determined to make use of the cystoscope after a short interval in order to confirm the diagnosis as far as possible. My manipulations, however, had so aggravated his condition that I decided to cut down upon the right kidney without any delay. The patient at the time of this operation was a physical wreck, and his outlook seemed far from promising. I made a transverse cut in the loin and exposed the kidney, which was as large as a cocoanut. I incised it and let out a great quantity of foul pus. After the pus had been evacuated and the cavity irrigated, I introduced my finger into the pelvis and discovered a calculus somewhat smaller than a hazelnut, consisting of a uric-acid nucleus covered with phosphatic deposits. This I removed. The kidney to the feel seemed to be wholly disorganized. Owing to the wretched condition of the patient I should not have dared to remove it at that time even had I been so inclined. Two parallel drainage-tubes were inserted into the kidney and the wound was packed with gauze. The gauze was gradually removed, and at the end of a week nothing was left in it except one kidney drainage-tube. His condition improved considerably after the nephrotomy, and at the end of two weeks I determined to remove the organ which I felt would otherwise always exist as a purulent focus. Without any fresh cut, by simply breaking down the edges of the wound, I gradually worked my way down to the kidney and peeled it out of its nidus. In doing this I found my hand and wrist quite cramped by the firm, hard walls of the cut and of the tissues about the kidney. At the first operation the tissues had been observed to be very soft, and

then the kidney was somewhat movable. In fact, since the first operation the margin of the wound and the tissues about the kidney had been packed with plastic lymph. In a very short time, however, I was able to pop, as it were, the kidney out of its position and to bring it outside the loin. The pedicle was then tied and the organ removed. This secondary nephrectomy occupied fourteen minutes. There was no shock at all after the operation. Since the removal of the kidney the urine has been clear and normally voided, and the patient has improved wonderfully. The kidney at the time of its removal was about three fourths the normal size, and, as the section through its substance shows, practically none of its renal secreting tissue remained. The section also shows numerous cavities which mark the site of former abscesses, and about several of these cavities are whitish masses which to the naked eye might suggest some form of new growth. Such masses are, however, made up of coagulation necrosis.



Dr. Fuller's specimen of disorganized kidney.

The following is a histological report of the case made by Dr. Henry T. Brooks, of the Post-Graduate Hospital:

Kidney presents a number (5–6) of excavations of variable size (see specimen), occupying the greater portion of the space normally taken up by the pyramids. Commencing at a point corresponding to the bases of the pyramids, the remaining kidney substance extends uninterruptedly to the capsule. This portion of the organ varies in thickness from one fourth to three fourths of an inch, is glistening, yellowish-white in color, and firm, dense, and resistant, except in that part directly encroaching upon the cavities, which is soft in consistence and of a decidedly yellow color.

Microscopical examination of sections made from this tissue and extending through its whole thickness—from capsule to cavity margin—shows almost complete obliteration of normal kidney structure and replacement by more or less dense bands of fibrous connective tissue and small round cells. In the neighborhood of the capsule, and for

some distance inward toward the pelvis, pure fibrous tissue appears to be the only constituent. As the walls of the cavity are approached, the fibrous tissue becomes less and less densely arranged—being more or less infiltrated with small round cells—until the margin of the cavities is reached, where the structure is almost wholly small round cells imbedded in a homogeneous or finely granular protoplasmic mass presenting the appearance of coagulation necrosis. Now and then a few very fairly well preserved renal cells and an occasional glomerulus in a state of complete fibrosis are observed in the advance from capsule to locality just mentioned. No perfect tubules or glomeruli could be detected in any portion of the sections examined. Had the sections not been knowingly taken from the kidney, it would have been almost an impossibility to determine their origin.

A CASE OF DERMATITIS HERPETIFORMIS.

BY GEORGE T. ELLIOT, M. D.,
Professor of Dermatology, New York Post-Graduate Medical School, etc.

THE following case of dermatitis herpetiformis is so typical in its entire clinical symptomatology and course that it would appear worthy of record. The repeated and constant report of similar instances of cutaneous disease has in the last few years greatly increased our knowledge of the general features which characterize it, as well as broadened our conception of its nature. At the same time, the diagnostic value of its symptoms is more fully appreciated, the disease is more readily and generally recognized, and no longer confounded with those one and other cutaneous processes which at various times in its course it may resemble, owing to the individual lesions present.

Male, aged fifty-six, a merchant, consulted me February 1, 1890. He had never been ill, and his domestic and business relations were entirely free from any such complications as would produce worry, anxiety, or lead to any moral or other shocks. Temperate, a moderate smoker and not given to any excesses, except indulgence in strawberries whenever obtainable, he could give no clew in his history suggesting the origin of his disease. The first outbreak was preceded for a year or more by a gradual dryness, harshness, and roughness of the entire skin, but especially of the hands, and in June, 1889, an intensely

itchy eruption appeared suddenly over his chest. It was thought to be "prickly heat," but, as it spread rapidly over the back and extremities, a physician was consulted. At that time, the lesions were papules and vesicles grouped and arranged in rings, and the diagnosis was made of "ringworm" complicated with eczema. The application of the remedies ordered led to extensive exfoliation of the epidermis, and immediately afterward, bullæ as large as a pigeon's egg appeared around the wrists, in the axillæ and in the groins. Similar lesions, pea to hazelnut in size, developed in crops generally over the body, except upon the back. During the succeeding six months, the eruption persisted almost continuously, though the type of lesion was not stated, relapse succeeding relapse, each separated by only short intervals of improvement. Intense, agonizing itching was present all the time, as well as a severe universal hyperidrosis, and violent clonic spasms of the extremities caused him much distress when lying down. By December of the same year his condition had considerably improved, and he went to Old Point Comfort. During the first two weeks he gained in strength, he slept better, the itching and sweating diminished, but he then received accidentally a severe moral shock. The following day, the pruritus returned and bullæ cropped out on the inner surfaces of the thighs. A few days later, papules appeared over the extremities, and the outbreak became progressively severer—papules, vesicles, bullæ, and erythematous patches developing in successive crops over the various portions of the body. Shortly after, he consulted Dr. Duhring in Philadelphia, who diagnosed the case as one of dermatitis herpetiformis, and later he came to New York and under my care.

On examination, the patient was found to be well nourished, his appetite and digestion were good, but the bowels for several months had been loose, three to four or more stools occurring every day. From two and a half to four quarts of urine were passed every twenty-four hours, frequent nocturnal micturition being a necessity. The amount would be increased whenever the itching was severe, or the patient became worried or depressed. The urine was limpid and very light in color, acid, and of a specific gravity of 1·019. No albumin or sugar. Urea, 1·60 per cent. Vesical and urethral epithelium, a few pus cells and small uric-acid crystals were found present under the microscope. No elevation of the temperature existed or took place while under treatment. The pulse was full and regular, but when he exerted himself one beat in about fifteen would be missed—a condition which had existed for twenty-five years. As far as could be ascertained, all the other organs of the body were normal. The mind was

clear, the brain active, no muscular weakness, no tenderness on pressure over the spine. The hair had turned very gray since the disease existed, but there was no alopecia. The beard had changed from brown to white. The nails of the fingers and toes were dystrophic, discolored, thickened and split longitudinally, and their growth was apparently retarded.

With the exception of the face, the entire body was deeply pigmented, but here and there were small islands of skin normal in color, and standing out in vivid contrast with the dark brown left by former outbreaks, with the red hue of the newer erythematous lesions and with the purplish and cyanotic tinge of those undergoing involution. On the upper arms and on the abdomen were many dirty, grayish-white, irregularly shaped spots, evidently superficial cicatrices caused by the scratching and wounding of the lesions. The skin in its entirety was much thickened and indurated, especially over the buttocks. Below the knees it was tense and shiny, though not œdematous. The lesions distributed over the surface were of all kinds, forms, shapes, and sizes. Vesicles, bullæ, papules, and erythematous bands and patches occurred alone on a surface, or were grouped together in a most peculiar and inextricable manner. On the face, bullæ alone were present. They were discrete or grouped, the size of a buckshot to a hazelnut, round or oval, linear or crescentic, or curving partly around a central bleb. Some were angular and stellate, others of uniform outline.

Over the body, discrete bullæ were distributed. They were tense, resistant, not rupturing easily, and contained a clear, light-yellow, neutral fluid. In some places, notably at the navel, a large central bulla was seen surrounded by a row of vesicles somewhat larger than a pinhead. These bullous lesions arose apparently from the skin, without being preceded by any redness or primary change. The vesicles were pinhead and a little larger in size and grouped together, the groups in some places being a handbreadth in size. Some were deep-seated, as though occupying the center of pre-existing papules. Only on the backs of the hands had the contents of either bullæ or vesicles become purulent, and when uninjured by scratching they dried up into thin, yellowish crusts. The papules varied in size from a small pea to a pinhead, bright or dusky red in color, and resistant. The larger ones were discrete, but the others were arranged in groups occupying small or large areas. The erythematous lesions were of most varied shape and form, and ranged in size from that of a nickel to patches occupying, for instance, an entire buttock. They were also represented by narrow, elevated bands, ring-shaped and inclosing a sunken-in, viola-

ceous center, or by segments of circles, or by gyrate or festooned lesions of varying length. In their evolution, they began as an erythematous solid efflorescence about the size of a nickel; the central portion soon subsided, becoming dusky red or cyanotic in color, while the red border, a quarter to a third of an inch broad, advanced. As progression took place, involution occurred *pari passu*, until a limit of growth seemed to be reached, and then the entire lesion disappeared, leaving only some pigmentation, or upon the red elevated margin a row of vesicles or papulo-vesicles developed. The lesion would then appear as made up of a dusky-red or brownish disk, entirely or partly encircled by a chaplet of distinct vesicles arranged in a uniform or in a more or less irregular manner. Separate vesicles never arose in the centers of these disks, nor were these latter encircled by more than one row of such lesions. Instead of the progressive enlargement taking place, sometimes disks appeared which, from the first, were surrounded by a vesicular border. There were also crescentic lesions and others representing some segment of a circle which appeared as primary efflorescences. In their advance over the surface they would join together and thus form gyrate and wreathlike figures of varying contour and extent. On the legs below the knees there were many excoriated places and superficial ulcerations, due to scratching and the tearing of the surface.

No particular course was followed in the evolution or involution of the lesions. They would appear suddenly, singly or in crops, and remain for several days, or they would come out and disappear in a few hours or in a day. These latter would leave no trace of their former presence, but the bullæ or vesicles would dry up into crusts, or, being ruptured by scratching, leave an excoriated surface which healed slowly. The papular and erythematous lesions, however, would change from a bright to a dusky red, then purplish, and when entirely gone only a brown pigmented area remained.

The subjective symptoms were intensely severe, and consisted entirely in intolerable itching and burning. In some degree they were always present, but there would be paroxysmal exacerbations of excessive severity, and more frequently at night, or whenever he removed his clothing and his skin became exposed to the air. These symptoms and the clonic spasms already referred to prevented sleep for some hours after he went to bed. The itching and burning would also become worse whenever the weather was stormy or rainy, or when the bowels were costive, or if any mental worry or anxiety supervened. Before the appearance of a crop of lesions, the sites upon which they were to appear would likewise itch and burn intensely. There was

a universal severe hyperidrosis also present, which added to his discomfort. Always existing on the trunk, it became severe upon the extremities only during the pruritic paroxysms.

While the patient was under treatment, there was progressive improvement, interrupted, however, by a succession of relapses of varying extent and intensity, and consisting of a single type of lesion or of multiform efflorescences. The occurrence of a relapse could not always be traced to any definite cause, though it would take place when there was a change from fine to bad weather, when any functional disturbance of the gastro-intestinal canal arose, or when he overtaxed himself mentally or physically. Gradually, however, these renewed outbreaks became less frequent and severe, the clonic spasms as well as the hyperidrosis ceased, the pigmentation diminished, the skin was less thickened and infiltrated, and, generally and markedly improved physically and mentally, the patient went home March 23d. He was then entirely free from any lesions, and had only occasionally a little itching. At the end of a few weeks, however, the cutaneous symptoms returned in some degree, but subsided shortly. In the following year there were several relapses, and finally he went to Europe for a number of months, and has since then remained comparatively well. The treatment he received while under my care consisted of general dietetic and hygienic measures. Ergot internally up to a drachm and a half three times a day, and ichthyol in carron oil externally. Besides these, baths of starch and white-oak bark were given daily. The ichthyol gave almost instantaneous relief to the burning and itching, and enabled him to obtain rest and sleep.

As I have already stated, this case presented in a most typical manner all the symptoms characterizing dermatitis herpetiformis, and in this it agreed with the many other examples of the disease which I have had under my care. That at times during its course it resembled to some extent in its lesions other diseases of the skin, is unquestionable—in fact, that is true in all cases of dermatitis herpetiformis—yet when the symptoms developed were taken as a whole, it was readily seen that each variation in aspect was simply an expression of a part of that pathological process now recognized and known in its variable and multiform phenomena as Duhring's disease. The right of distinct existence is not, however, accorded to dermatitis herpetiformis by all, as only in the last year Kaposi* has denied that it was a disease of itself, but rather a sort of collective conception, made up in part of erythema multiforme and of other bullous affections, urticaria, etc.,

* Proceedings of Fifth German Dermatol. Congress.

and in part of pemphigus. As far as pemphigus is concerned, I most assuredly can affirm that this patient was not affected with that disease. There were at various times during its course bullæ on the surface, it is true, but these were greatly in the minority; they were distributed here and there, but were relative exceptions in the great mass of other lesions with which the surface was covered. Papules and vesicles arranged in groups were the predominant lesions, as well as erythematous patches of various shapes. I can not see how a pemphigus could be made out of such a case, nor how its clinical history, phenomena, behavior, or course could be reconciled with those of pemphigus as defined and described by authors. Pemphigus acutus, a severe disease, with systemic reaction, fever, etc., and usually ending fatally in a few days, does not come into consideration here, nor does pemphigus foliaceus or vegetans, but only pemphigus vulgaris chronicus. This disease is defined by Hebra* as characterized by repeated outbreaks of *bullæ*, and no other lesion is described or mentioned by him in the whole article. Erasmus Wilson,† Tilbury Fox,‡ Hardy,# Simon,‖ Crocker,^ Brocq,◊ Zeisler,‡ and any number of others, have not deviated from this, Hebra's definition, beyond mentioning the occasional presence of some erythematous patches or urticarial wheals upon which bullæ subsequently developed. Kaposi↕ himself, in his book (1883), and again in its newer edition (1893), defines pemphigus as a "bullous eruption, characterized by outbreaks of bullæ," mentioning that erythematous phenomena of various kinds accompany it. No other lesions are described, and in the article devoted to the subject he agrees with those other writers mentioned. When the description of pemphigus as obtained from the works of these eminent writers is compared with that of dermatitis herpetiformis as given by Duhring, Brocq, and others, and also as observed by myself in many cases, it is certainly difficult to understand a failure to recognize Duhring's disease as distinct from pemphigus: on the one hand, a process of which the essential symptoms—the *sine qua non*—are bullæ; on the other hand, a disease in which bullæ do occur, but only as one of many other types of lesions, and, moreover, one which in my expe-

* Hebra. Hebra and Kaposi, *Hautkrankh*, 1872.
† Wilson. *Diseases of the Skin*, 1867.
‡ T. Fox. *Skin Diseases*, 1873.
Hardy. *Traité des maladies de la peau*, 1886.
‖ Simon. *Hauthkrankheiten*, 1851.
^ Crocker. *Diseases of the Skin*, 1888.
◊ Brocq. *Traitement des maladies de la peau*, 1890.
‡ Zeisler. Morrow's *System of Syph.*, etc., 1894.
↕ Kaposi. *Pathologie und Therapie d. Hautk.*, 1883 and 1893.

rience at least, is more uncommon than any other of the eruptive phenomena seen in the process. Besides these, in dermatitis herpetiformis the subjective symptoms are intense, the itching, burning, and paræsthesia always severe; in pemphigus they are very slight, and often entirely wanting. The latter disease is accompanied by severe systemic symptoms, the patients become emaciated and prostrated, while in the former the individual is in a relatively good condition of health, even though the process runs a long and chronic course. The mortality of pemphigus is certainly very high, and it has always been considered a serious disease; that of dermatitis herpetiformis is infinitesimal. I do not remember more than one case of pemphigus vulgaris which I have seen, which has not ended fatally, while in over forty of dermatitis herpetiformis which I have treated only one died, and then from septicæmia, the origin of which was very doubtful.*

In view of these striking differences between the two forms of eruption, differences which have repeatedly been stated, it is therefore not surprising that the consensus of opinion has accepted and substantiated Duhring's description, and that dermatitis herpetiformis has become recognized, with few exceptions, as a distinct entity. It may, however, be advanced that such cases are nevertheless examples of pemphigus vulgaris, being of the type pemphigus pruriginosus. Still, this latter is now separated from pemphigus, and certainly clinically it bears no resemblance to it. Kaposi† specifically states that the picture presented by pemphigus pruriginosus is entirely different from the usual one of pemphigus vulgaris (*ein von dem gewöhnlichen ganz abweichendes Krankheitsbild*), explaining the absence of bullæ by the fact that the erythematous lesions are scratched before the bullæ can form. I most certainly would agree with him that it bears no resemblance to pemphigus vulgaris, but, being so markedly representative of dermatitis herpetiformis, it is not surprising that it has come to be generally regarded as belonging in this latter category.

It is hardly necessary to make a differential diagnosis between this case of dermatitis herpetiformis and erythema multiforme bullosum, or of other type, or to take urticaria bullosum into consideration. Only careless observation could allow these eruptions to be confounded with the former one; and I would only state, in conclusion, that the case reported here was neither a pemphigus, nor an erythema multiforme, nor an urticaria, but a most typical and characteristic example of dermatitis herpetiformis.

14 West Thirty-third Street.

* Elliot. *American Journal of the Medical Sciences*, 1895. † Kaposi, *loc. cit.*

Society Transactions.

THE NEW YORK DERMATOLOGICAL SOCIETY.

249th Regular Meeting, held on Tuesday Evening, January 28, 1896.

Dr. C. W. Cutler, *President, in the Chair.*

A Case for Diagnosis.—Presented by Dr. S. Lustgarten.

The patient was a young girl, with peculiar lesions in the mouth, which developed about two years ago, and have since then considerably increased in number. The lesions were very numerous on the inner side of the upper and lower lip and cheeks, and an isolated one was situated near the uvula and another in the sublingual region. They vary in size from a small shot to a split pea, lesions somewhat slightly papillary in character, resembling adenomatous tissue. They were not attended by any inflammatory or subjective symptoms. The patient's general health was excellent. The lesions gave rise to some discomfort on account of their number.

Dr. C. W. Allen said he did not care to venture a positive diagnosis. The lesions looked like benign growths, papillary in character.

Dr. Bronson said that while he had observed isolated elevations on the lips like these, he had never seen them occur in clusters, as in this case.

Dr. Fordyce thought the lesions were adenomatous in character, possibly originating in the mucous glands. Their true character could only be established by a microscopical examination.

Dr. George T. Jackson also considered the lesions adenomatous in character. He thought that the condition was somewhat akin to that seen in milium.

Dr. Fox said the lesions seemed to be the result of a follicular trouble of the mucous membrane. It was not uncommon to find a few such elevations on the mucous surface of the lips, but he had never seen such an extensive eruption.

Dr. Sherwell suggested that the growths might be of the same nature as the adenoid vegetation frequently found in the vault of the pharynx in young subjects.

Dr. Lustgarten, in closing the discussion, said that this was the first case of the kind coming under his observation. He agreed with Dr. Fordyce that only a microscopic examination would enable us to make a positive diagnosis. The lesions at times showed a papillary character, like that of the soft, flat warts sometimes seen on the faces of children. The fact that the lesions were limited to the area occupied by the mucous glands would indicate that there was some connection between the two.

A Case for Diagnosis.—Presented by Dr. Fox.

The patient was a child, with a number of colorless patches, papular in character, on the arms and legs. The lesions corresponded very closely to those described as lichen scrofulosorum. In another case, recently coming

under his observation, the lesions were similar to those described by Tilbury Fox as cacotrophia folliculorum.

DR. SHERWELL said he was not inclined to regard the case as one of lichen scrofulosorum; it looked more like a neurotic form of eczema. In a somewhat similar case, recently coming under his observation, the lesions faintly resembled those of ringworm: but he had in that case said, and would in this case certainly say, that it was eczematous and of the above order.

DR. FOX remarked that in his case the lesions had existed since a very early age, getting better in summer, worse in winter.

DR. JACKSON said he did not think the case was one of lichen scrofulosus. It corresponded more closely to what Crocker had described as lichen pilaris, consisting of an eruption of small papules, occurring in groups, and especially affecting the extremities of children. In Crocker's description, he referred to the protruding spines, which were very evident in this case when the patient first came under observation.

DR. A. R. ROBINSON said the case did not impress him as one of lichen scrofulosorum, either in the appearance of the lesions or the general appearance of the patient. He had observed a number of similar cases in children, and had classed them as erythematous eczema. In Dr. Fox's case, he noticed a well-marked patch of erythematous eczema on one wrist.

DR. FORDYCE said he was inclined to regard the condition as a mild form of ichthyosis.

DR. E. B. BRONSON said this condition occurred under varying circumstances, and he did not regard it as extremely rare. Some years ago he presented a case of prurigo in which there was a condition of innutrition of the skin, producing an appearance similar to that seen in ichthyosis and not unlike that observed in this case. He had seen the same condition occur in adults. The eruption may resemble an eczema, and it often becomes eczematous, but primarily there is no catarrhal process connected with it. He regarded it as an imperfect development of the epidermis due to a lack of proper innervation.

DR. R. W. TAYLOR said he failed to see anything in the child's condition which would warrant the adjective scrofulosorum. He regarded the case as a mild, persistent form of superficial eczema.

DR. C. W. ALLEN said he did not consider the case as either an eczema or lichen scrofulosorum, although he had seen cases of the latter affection in which the ordinary manifestations of scrofula, such as enlarged glands, etc., were absent, and the children appeared to be in otherwise good health. He agreed with Dr. Jackson that the case shown by Dr. Fox resembled very closely those described by Crocker. The condition was probably of congenital origin and closely allied to ichthyosis. In a similar case coming under his observation in an adult the small projecting spines, as noted in this case, were also present, and a microscopical examination showed that they were made up of from two to five fine hairs which had been detached from the hair-bulb, and instead of being cast off had been retained in the follicle, imbedded in a mixture of epithelia and sebaceous matter and thus protruded slightly from the mouth of the follicle as a harsh cone. The speaker said he regarded this case as one of keratosis or lichen pilaris.

DR. BRONSON said he would like to know what Crocker means by lichen pilaris. The description given by him of that disease does not resemble that

observed in this case. His disease (Crocker's) was a distinct inflammation about the follicles, sluggish in its course, with a certain amount of redness, and attended with some keratosis.

Dr. Jackson said he did not mean to imply by his remarks that Crocker was right in establishing the condition he described as a separate disease; he simply expressed the opinion that the lesions in Dr. Fox's case corresponded with the description given by Crocker of lichen pilaris.

Dr. Taylor said he was surprised to hear so much said about lichen scrofulosus. That condition, as described by Hebra, is certainly very rare. He had probably not seen more than two cases of it in his life.

Dr. Klotz said he did not think the case was one of lichen scrofulosus. It resembled an eczema more than any other disease. The lesions on the arm showed a distinct inflammation of the follicles. Possibly, he said, the case belonged to the class of eczema folliculare.

Dr. Elliot did not regard the case as one of lichen scrofulosus. In some respects it resembled those cases which the French have described as *neuro-dermite circonscrite.*

Dr. Lustgarten said that cases of lichen scrofulosorum are very rarely seen in this country. The more common manifestations of scrofula are much more infrequent here than in Europe. Dr. Fox's case, he said, could not be regarded as one of lichen scrofulosorum: the lesions are too superficial, and there are no glandular enlargements, such as are usually present in lichen scrofulosorum. Dr. Lustgarten said he was inclined to make the same diagnosis as Dr. Fordyce; there seems to be a congenital malformation of the skin closely allied to that seen in ichthyosis or lichen pilaris.

Dr. Fox said he had never seen nor heard of a case of ichthyosis in which the lesions appeared in spots, not even in ichthyosis hystrix. In this case there are patches with perfectly healthy skin between, and he expressed the opinion that, although the disease may be a congenital affection of the horny layers, it is entirely distinct from what we ordinarily recognize as ichthyosis. While in some respects it resembles a follicular eczema, yet the colorless, superficial papules which are present in some of the patches differentiate it from that affection. It is true that there may be an eczematous condition superadded, but he would not regard it as an eczema nor as keratosis pilaris. It bears some resemblance to what Crocker has described as lichen pilaris, but the spines which he regards as essential are not present in this case. Hebra has described as lichen scrofulosorum an eruption which is characterized by these colorless papules, occurring in well-marked, circumscribed groups, and the speaker said he had seen two or three similar cases in this country. In certain cases of acne cathecticorum he had seen well-marked patches of lichen scrofulosorum, and these may occur in persons who are not markedly strumous. While the eruption in this child does not appear on the abdomen, and there are no other symptoms of scrofula, yet he considered that the eruption was allied to that class of which lichen scrofulosorum is one phase, and to which some general term will perhaps be applied when we come to understand them better. The grouping of the follicles he considered an essential feature of the eruption in this case, the redness being merely secondary.

Dr. Allen remarked that in the case under discussion the lesions were almost entirely confined to the extensor surfaces of the arms and legs, where the hair follicles are not abundant, while the flexors were free.

DR. TAYLOR said the true history of the case would probably show that the eruption is worse in winter, fading in summer, and that it is eczematous in character.

DR. ELLIOT referred to the fact that the lesions were absolutely symmetrical and occupied both extremities. This suggests a neurotic origin for the process.

A Case for Diagnosis.—Presented by DR. FORDYCE.

The patient was a woman, aged thirty-six years, with two lesions on the left cheek. They consisted of soft, sharply defined infiltrations in the skin, of extravasated blood and disintegrated tissue. They first appeared about eight years ago. The lesions bleed very readily.

DR. ALLEN said the lesions were either stigmata of hysteria or sarcoma. From the length of time that had elapsed since the onset the malignant nature of the lesion was very doubtful.

DR. KLOTZ suggested that the lesion might be of epitheliomatous nature.

DR. JACKSON said that while he did not care to venture a positive diagnosis, he was inclined to believe that it was the result of an infective process. In a similar case recently coming under his observation he destroyed the lesion by means of electrolysis, and the patient afterward developed smaller spots around the site of the original lesion. He expressed the view that lesions of this character belong to the pigmented sarcoma tribe.

DR. FOX referred to two similar cases coming under his observation, both in old women over seventy years of age. He made a diagnosis of pigmented sarcoma. The lesions were easily and, as he believed, permanently removed.

DR. LUSTGARTEN said he hesitated to accept the diagnosis of sarcoma because of the long duration of the lesion. It had existed eight years, during which period it had shown very slight tendency to extend. He was inclined to regard the lesion as hysterical in origin.

DR. FORDYCE, in closing the discussion, said that if the condition was due to hysteria we would rather expect to find similar lesions develop elsewhere. Pigmented tumors are apt to make more rapid progress than this one has done. The feel of this one is soft, much like a lupus; still, its long duration militated against that diagnosis. The speaker said he would make a microscopical examination and report the result.

A Case of Copaiba Eruption.—Presented by DR. FORDYCE.

The patient was a young man with an extensive eruption of erythema multiforme covering the trunk and extremities. For some days previous to the onset of this eruption he had been taking a patent medicine, which has a balsamic odor and probably contains balsam of copaiba.

DR. ELLIOT referred to a similar case coming under his observation in which the eruption was the result of taking cuticura resolvent.

DR. FORDYCE stated that turpentine may produce an eruption very similar to that often following the use of certain balsams. Some years ago he saw a generalized erythematous eruption resulting from chewing spruce gum, which contains turpentine.

An Anomalous Case of Psoriasis.—Presented by DR. FOX.

The patient was an old man, with a scaling eruption on the scalp of many years' duration and a more recent eruption on the body. The speaker said he took it to be a case of psoriasis, although the distribution of the lesions upon

the chest was very characteristic of an eczema. Some of the lesions on the body were difficult to diagnose, partaking as they do of the character of both eczema and psoriasis. Dr. Fox expressed the opinion that this case was one of psoriasis, and there existed a distinct pityriasic disease which stood midway between an eczema and a psoriasis.

Dr. Elliot said he did not think the case was one of psoriasis. He regarded it as one of seborrhoic eczema.

Dr. Robinson thought the case was one of psoriasis. The large number of isolated lesions, and their clinical character, justified that diagnosis, and the scaling is quite as marked as we often see it in that disease.

Dr. Jackson said he regarded the case as one of seborrhœal eczema, although before that condition was described this would undoubtedly have been classed as a psoriasis. In this case the knees and elbows, which are commonly the seats of psoriatic lesions, are entirely spared.

Dr. Sherwell thought the case was one of psoriasis, although somewhat anomalous in the location of the lesions and their greasy appearance.

Dr. Klotz said that he agreed with Dr. Elliot's diagnosis of seborrhœal eczema. He called attention to the slight scaling and the unusual color of the lesions, and referred to a similar case recently coming under his observation, in which the lesions on the elbows and knees were decidedly like those of psoriasis, while those on the body were of a mixed character, and on the scalp there was seborrhœa, and nothing but seborrhœa of the most distinct and typical form.

Dr. Piffard regarded the case as one of psoriasis. He disagreed with the idea that a so-called seborrhœal eczema is an eczema at all. He also inquired on what grounds an eczema can be called parasitic ; he had certainly never seen a case of parasitic eczema.

Dr. Allen expressed the opinion that this was one of those cases in which the diagnosis should depend somewhat upon the effect of treatment. If, as Dr. Elliot had suggested, the case was one of seborrhœal eczema or a dermatitis, a short course of treatment would probably cause most of the lesions to disappear, while, on the other hand, if the case was psoriasis, treatment would probably prove of very little benefit.

Dr. Elliot replied that a cure would depend upon the kind of treatment, as some seborrhoic eczemas are more difficult to remove than psoriasis. In this particular case he would suggest the use of resorcin and sulphur in proper proportions.

Dr. Fordyce said he considered the case to be one of psoriasis. He suggested that some cases of seborrhœal eczema and psoriasis are amenable to the same treatment—namely, pyrogallic acid and chrysarobin.

Dr. Lustgarten said that long before the term seborrhœal eczema was in vogue, cases like this were distinguished from psoriasis. They were classified as psoriasiform eczema. In order to arrive at a correct diagnosis, we must take the whole case into consideration: the patient is an old man who has never before had an eruption similar to this. The scaling is slight and the lesions are greasy and of a peculiar yellow shade. The location of the lesions is atypical. The speaker said he would classify the case as a psoriasiform eczema, which would yield readily to a mild antipsoriatic treatment (pyrogallol, two to five per cent ol. rusci, etc.), and which as a further point of differentiation could be radically cured.

DR. FOX said that for many years this man had had a scaling eruption on the scalp and within a few months these various lesions had developed on the body. We all knew that typical psoriasis would persist on the head for years, and then suddenly, for some unknown reason, would develop on the body. He saw no reason why the eruption should be regarded as parasitic. We had all seen cases of eczema which presented the appearance of psoriasis, and *vice versa*. The affections may merge into one another, and we sometimes see cases which are midway between an eczema and a psoriasis. This affection is distinct, and can hardly be called a hybrid condition. There is a pityriasic appearance of the skin, the lesions on one hand showing no tendency to ooze, as in eczema, while on the other hand they never present the circumscribed silvery patches of psoriasis. In the case under discussion there are numerous scales, which can be scraped off, leaving bleeding points. In psoriasis we may have greasy scales, and the fact that the knees and elbows are not involved is of no great importance, as these locations are often spared in unmistakable cases of psoriasis.

DR. ELLIOT, in reply to Dr. Piffard, said that diplococci had been found in the lesions of seborrhoic eczema; pure cultures had been made, the disease had been produced by inoculation of these cultures, and the diplococci recultivated from the lesion produced. He had had the pleasure of reporting these facts in a paper read at Montreal, and containing the work done by Dr. Merrill on that subject.

A Case of Sarcoma of the Ear.—Presented by DR. SHERWELL for DR. THOMAS F. MCCLEARY.

The patient was an unmarried girl, aged twenty-four, who first noticed a growth on the lobe of her left ear in April, 1895, which was pedunculated in character, and was removed at that time by another physician, and on examination was pronounced cystoma. When it recurred, as it soon did, the tumor was dark-colored, hard, and fibrous in character. There is now enlargement of the glands in the neck. The tumor was removed on September 28, 1895, by Dr. McCleary, a V-shaped piece being cut out of the ear. It recurred within three weeks, and has since then increased in size very rapidly. Dr. Sherwell, who first saw the patient about two weeks ago, said he regarded the lesion as a pigmented fibrous sarcoma. He recommended a most thorough removal of the tumor and glands, and arsenical treatment to follow. He presented the case as having some singular features, and one on which he requested advice as to the best method of treatment.

DR. P. A. MORROW said he thought the case was one of sarcoma.

DR. FOX said the lesion was evidently a malignant one. He mentioned the fact that epithelioma of this portion of the ear is not uncommon.

DR. SAMUEL ALEXANDER made a diagnosis of sarcoma. He thought a radical operation was indicated, which included the complete removal of all the involved glands in the neck.

DR. ROBINSON regarded the lesion as a combination of sarcoma and hæmato-lymphangioma.

DR. PIFFARD advised that the lesion be removed and its true nature ascertained afterward.

DR. ALLEN agreed with those who diagnosticated the case sarcoma.

DR. LUSTGARTEN diagnosed the case as one of sarcoma. He expressed the opinion that in cases of this character an operation may do more harm than

good, as the disease soon recurs and spreads more rapidly. Some of these cases have done well under arsenic.

Dr. Bronson said that in a similar case coming under his observation a thorough operation was followed by an early recurrence, and the disease soon became disseminated throughout the entire body. The man suffered intensely from neuralgia and died of exhaustion. The autopsy showed considerable involvement of the nerves.

Dr. Fordyce said that the true nature of the growth can only be determined by the aid of the microscope. Some of these pigmented tumors are sarcomatous, others carcinomatous. They often involve the lymph glands, and others spread through the blood-vessels. The latter, according to some investigators, are sarcomatous, while those involving the lymph vessels are carcinomatous. In this case the lymph vessels seem to be involved.

NEW YORK ACADEMY OF MEDICINE.

Section on Genito-Urinary Surgery: Stated Meeting, held on Tuesday Evening, February 11, 1896.

Dr. W. K. Otis, *Chairman.*

Exhibition of a Vesical Calculus removed by Suprapubic Operation.—Dr. J. R. Hayden showed a calculus which he recently removed from the bladder by suprapubic operation. The stone weighed three hundred and sixty grains, and had been carried by the patient for a year with very slight discomfort, the only symptom which it gave rise to being occasional vague pains over the bladder. There was only a mild degree of cystitis. An interesting feature of the specimen was its pointed extremities, the points seeming to correspond to the ureteral orifices.

Dr. L. Bolton Bangs said that calculi sometimes remain in the bladder for a long time without giving rise to any pronounced symptoms. He recently saw a man, aged sixty-seven years, who carried a stone in his bladder for five years, the only symptom being pain on jolting, and when suprapubic pressure was made. There was no cystitis until recently, when a very severe one was produced by infection, due to the introduction of a dirty instrument.

Dr. John F. Erdmann referred to a similar case coming under his observation.

The Chairman said the points at the extremities of the stone shown by Dr. Hayden certainly looked as if they might have been in the ureters; still, this was almost incredible, as they could not have been so situated for any length of time without giving rise to serious symptoms, which did not exist in this case.

A Case of Double Tubercular Epididymitis.—Presented by Dr. Irwin Hance.

The patient was a man aged thirty; married; family history negative. His wife has been suffering from pulmonary tuberculosis for the past eighteen months or longer. About a year and a half ago he noticed that his micturition was becoming more frequent than usual, and he was obliged to

get up once or twice at night. His bladder also became somewhat irritable. These symptoms persisted for about a year, although his general health was not impaired. About four weeks ago the right testicle began to swell, and he experienced some pain and difficulty in urination; a week later the opposite testicle became swollen, and the inguinal glands on both sides were slightly enlarged. The specific gravity of the urine was 1·027; it contained no albumin. The microscope revealed a large number of pus cells and a few tubercle bacilli Dr. Bangs, who afterward saw the patient, also found tubercle bacilli in his urine. A diagnosis of double tubercular epididymitis was made, probably secondary to a focus of disease elsewhere. An examination of the chest revealed no positive signs of pulmonary disease.

Dr. Hance said that while at Saranac Lake he had several cases of tubercular epididymitis under his care. One man, a patient of Dr. F. Tilden Brown, remained at the Sanitarium for about eighteen months, during which time he improved so much that he returned to the seashore, where he had formerly been employed. Within three weeks after leaving the mountains he had a relapse, and died two or three months later.

DR. C. L. GIBSON said that sea air is included by many writers in the list of therapeutic measures in the treatment of tuberculous patients. He inquired whether such patients often did badly when they were sent off on a sea voyage.

DR. BANGS referred to the operative treatment in cases of tubercular epididymitis. His own practice is not to castrate these individuals unless the pain they suffer is so severe that it impairs the general vitality, or unless there is a suppurative process which can not be relieved by a more conservative operation, such as curetting. He has seen one instance in which a surgical traumatism immediately precipitated an extension of the disease into the opposite testicle and other parts of the body.

As to the question of what climate is best suited to these cases, no definite answer can be given. Some patients, who are in the habit of going away every year, know from their own experiences whether they are more benefited in the mountains or at the seashore. Generally speaking, most of them are best off in a high, dry atmosphere.

The CHAIRMAN said that several tuberculous cases under his observation who went to the seashore did badly. In one case of tubercular cystitis the disease almost immediately became general.

Exhibition of a Post-mortem Specimen of a Prostate Gland after a Double Castration.—By DR. CHARLES B. KELSEY.

The specimen was removed from a man aged sixty-nine years, who was admitted into the Post-Graduate Hospital on December 2, 1895, complaining of the usual symptoms of enlarged prostate, which were present in a marked degree. Double castration was performed two days after the man's admission. Dr. Kelsey said that he would not have undertaken so radical a step were it not for the fact that the man had a large scrotal hernia and a hydrocele, and while operating on these he thought it perfectly justifiable, in view of the man's prostatic condition, to remove the testicles also. The operation proved of absolutely no benefit, so far as the symptoms referable to the enlarged prostate were concerned. In fact, the bladder symptoms became so severe that on December 28th perineal section was performed.

The patient died on January 14, 1896, about six weeks after the original

operation, death being due to parenchymatous nephritis. The prostate was removed, and both a gross and minute microscopical examination failed to reveal a change of any kind in that organ.

Dr. Eugene Fuller said he had examined Dr. Kelsey's patient both before and after castration had been performed, and he could not make out any change in the size of the prostate. So far as he knew, this was the second case on record in which the prostate had been examined after death. In the first case, which was reported by Griffiths in England, the patient died three weeks after double castration had been performed, and the gland showed an amazing amount of atrophy.

Dr. Thomas H. Manley said the case reported by Dr. Kelsey did not strike him as one in which the operation of double castration for enlarged prostate could be fairly tested, inasmuch as there was a triple operation performed.

Report of a Case of Nephrectomy Secondary to Nephrotomy.*—By Dr. Eugene Fuller.

Some Acute and Chronic Conditions of the Prostate Gland.—Dr. L. Bolton Bangs read a paper on this subject.

He stated that although the prostate is a sexual organ, its relation to the urinary bladder is such that it is more or less acted upon by the act of urination. There is no back door for the escape of urine and semen. These fluids must come through the prostatic portion of the urethra, and the more the latter functionates the more the diseased prostate suffers. Moreover, congestion of this organ stimulates the sexual nerve centers, which in turn react upon the prostate, and sexual activity becomes an additional aggravation. Brain and prostate reciprocate in their effect upon each other. Therefore the prostate has no rest, and is heavily handicapped when Nature undertakes its repair. From the age of puberty onward it is liable to lesion, and the man who escapes without some damage may well rejoice.

The speaker expressed the opinion that enlargement of the prostate begins earlier than is generally supposed. Sir Henry Thompson says it rarely makes its appearance after seventy. Dr. Belfield has reported a case at forty-three; Dr. Packard, of Philadelphia, at forty-five; Dr. Mudd removed an enormously enlarged prostate from a young man aged twenty-seven. Dr. Bangs said he himself had seen prostatic enlargement in young men of about forty. He believed the condition began during the active period of sexual life. The facts bearing upon these cases are extremely difficult to arrive at. Every man knows his own sexual history, very often to his great regret, and it is difficult sometimes to get a correct statement of his sexual life from boyhood upward. If we consider the facts that come to our knowledge as confidential advisers, which often include, first, the habit of masturbation; second, excessive sexual indulgence, not necessarily the act of coitus, but that prolonged indulgence with women who permit sexual relations persisting for hours at a time, but do not permit intercourse; and, third, the varied excesses of married life—if we consider these facts we will usually find sufficient cause for overgrowth of the prostate.

Dr. Bangs said he was not prepared to take the absolute position that all cases of prostatic enlargement (of course, leaving out tumors) are due to a

* See page 146.

preceding life of sexual hyperæmia, nor is he ignorant of the fact that this has been discussed long ago, but he had enough cases on record, carefully examined, and from whom he had obtained a clear and positive history from boyhood upward, to warrant him in suggesting this line of observation, which he hoped might lead to clearer ideas in regard to the ætiology of this disease.

In discussing the question of treatment, the speaker said that each individual must be studied and treated according to the conditions present, and these will vary from time to time. Of course, if the cause be ascertainable, it must be stopped. For the local conditions in the acute stages, as well as for the various reflex sensations, much relief may be obtained by the application of heat, such as hot sitz-baths and injections of hot water into the rectum. In his experience heat is more beneficial than cold. Local treatment to the urethra and prostate may be necessary; this includes the introduction of sounds, applications of silver nitrate, etc. Another and very important aid is massage of the prostate through the rectum, but this should not be instituted until the more acute symptoms have subsided.

The treatment of the chronic form of enlarged prostate properly resolves itself into (1) the palliative and (2) the radical. In a certain proportion of these cases the palliative treatment, carefully carried out, is all that will be required. In those cases which demand operative relief the choice has heretofore lain between drainage, either temporary or prolonged, and some form of prostatectomy. The first certainly presents a means of easy and speedy relief to present suffering. The operation of prostatectomy has recently been modified and improved, but taking the cases of all operators together the death-rate is still very high—from twenty to twenty-five per cent. Instead of this, we have now another operation of choice—namely, double castration, which was recently suggested by Dr. J. William White, of Philadelphia. His experimental and clinical work has been recently laid before the profession, and although its results are not yet positive, it is but fair to say that enough testimony has been advanced for us to believe that there are cases which will be benefited by the operation of double castration.

DR. SAMUEL ALEXANDER said that in spite of the extremely attractive and persuasive manner in which this subject had been presented by Dr. Bangs, he was in no wise convinced that sexual hyperæmia is responsible for prostatic hypertrophy in after life. The former is so common that if it was the active and efficient cause of prostatic hypertrophy we should see more of those cases than we do. It is very possible that it bears some relation to it, but the facts at our command do not warrant us in accepting it as the active cause.

Regarding the question of operative interference in prostatic hypertrophy, Dr. Alexander said he did not think that the operation of double castration should be offered to any man suffering from this condition without putting a very large question-mark after the statement that it will afford him relief. In spite of all that has been done in this direction, and in spite of all that has been written, the operation must still be regarded as a physiological experiment. The speaker said he had seen nothing in the literature on the subject to alter his previous judgment, and he regarded it as a very serious mistake on the part of genito-urinary surgeons to give the operation their sanction at this stage of our knowledge concerning it. The speaker said he was willing to admit that in some instances the operation seemed to have relieved the

symptoms, but he is not prepared to say that it had been long enough before the profession to warrant their approval.

DR. BANGS, in closing the discussion, said he was well aware of the difficulty in proving the theory that prostatic hypertrophy was dependent upon sexual hyperæmia in early life. There were certain other facts bearing on this subject which he had been unable to embody in a paper of this character. Regarding the operation of double castration in cases of prostatic overgrowth, the speaker said he had never performed it. He had proposed it to several patients, who declined to give their consent to it, probably because he was not able to assure them with any degree of positiveness that it would afford relief.

Selection.

The Treatment of Gonorrhœa with Argentum-Casein (Argonin). A. JADASSOHN (*Arch. f. Derm. u. Syph.*, vol. xxxii, fasc. 1 and 2).

Argonin is a combination of silver and casein, a metal-albumin compound in the form of a white powder, soluble in water by careful warming, and according to concentration gives a more or less opalescent neutral solution, which must be kept in a dark bottle. The maximum solubility is ten parts in one hundred parts of water. Fifteen parts of argonin contain as much silver as one of nitrate of silver. It does not form a precipitate when mixed with liquids containing salt or albumin, or both. A solution of 15 : 6,000 destroys the gonococcus in ten minutes, but a more concentrated solution (15 : 700) accomplishes the same end in one minute. The irritation produced even by a strong solution of argonin is far less than that caused by a solution of nitrate of silver or argentamin.

The author, accepting as a basis for gonorrhœal treatment the destruction of the gonococcus in as short a time as possible without producing inflammation or injuring the mucous membrane, found in argonin, on account of its foregoing properties, the nearest approach to a fulfillment of these indications. He has used it in seventy-two males and one hundred and fifty-eight females suffering with acute and chronic urethral gonorrhœa.

In anterior urethritis the patient injects, by means of an ordinary syringe, ten cubic centimetres of a 15 : 3,000–4,000 solution of argonin three or four times daily, keeping the injected liquid for ten or fifteen minutes in the urethra. The strength of the solution is gradually increased up to 15 : 750. Even a solution of 7·5 : 100 injected in the anterior urethra produces neither irritation nor pain.

Only in special cases is irrigation of the anterior urethra by means of a catheter necessary. In posterior urethritis a solution of 7·5 : 100 may be at once applied by means of a urethral syringe attached to a Guyon's catheter. In female patients injections were used of the same strength, and the cervical canal cleaned with a Playfair's sound twice daily. The gonococci disappear after an average treatment of three or four weeks. Careful microscopical examinations failed to discover them. As argonin has no astringent properties, ichthyol is of use after the disappearance of the gonococci.

The author arrives at the following conclusions :

1. Although argonin does not coagulate albumin, nevertheless it destroys the gonococci in a short time.

2. Even strong solutions (7·5 : 100) do not inflame or produce caustic effects ; hence they are useful even in acute anterior and posterior gonorrhœal inflammations of the urethra. LAPOWSKI.

Item.

Programme of the Third International Congress of Dermatology.—To be held in London, August 4 to 8, 1896.

Tuesday, August 4th.—Preliminary business. 12 M.: Presidential address. 3 P. M.: Subject: Prurigo. (1) Dr. Besnier (Paris); (2) Prof. Kaposi (Vienna); (3) Dr. J. C. White (Boston); (4) Dr. Payne (London).

Wednesday, August 5th.—9 A. M.: Clinical Demonstration of Cases. 10.30 A. M.: Subject: The Ætiology and Varieties of Keratosis. (1) Dr. Unna (Hamburg); (2) Dr. H. G. Brooke (Manchester); (3) Prof. V. Mibelli (Parma); (4) Dr. W. Dubreuilh (Bordeaux). 3 P. M.: Papers. 10.30 A. M.: Subject: Syphilitic Reinfection. (1) Prof. Fournier (Paris); (2) Prof. Lang (Vienna); (3) Mr. Alfred Cooper (London); (4) Dr. Fitzgibbon (Dublin). 3 P. M.: Papers.

Thursday, August 6th.—9 A. M.: Clinical Demonstration of Cases. 10.30 A. M.: Subject: The Connection of Tuberculosis with Diseases of the Skin other than Lupus Vulgaris. (1) Dr. J. Nevins Hyde (Chicago); (2) Dr. Hallopeau (Paris); (3) Dr. Radcliffe Crocker (London); (4) Dr. G. Riehl (Vienna). 10.30 A. M.: Subject: The Duration of the Period of Contagion of Syphilis. (1) Mr. Hutchinson (London); (2) Prof. Campana (Rome); (3) Prof. Lassar (Berlin); (4) Dr. Feulard (Paris). 2 P. M.: Subject: Ringworm and the Trichophytons. (1) Dr. Sabouraud (Paris); (2) Prof. Rosenbach (Göttingen); (3) Mr. Malcolm Morris (London). Many contributions to this debate are promised.

Friday, August 7th.—9 A. M.: Clinical Demonstration of Cases. 10.30 A. M.: Subject: The Nature and Relations of the Erythema Multiforme Group. (1) Prof. de Amicis (Naples); (2) Dr. T. H. Veiel (Stuttgart); (3) Dr. P. A. Morrow (New York); (4) Dr. Stephen Mackenzie (London). 10.30 A. M.: Subject: Malignant Syphilis. (1) Prof. Haslund (Copenhagen); (2) Prof. Niesser (Breslau); (3) Prof. Tarnovsky (St. Petersburg). 2 P. M.: Clinical Demonstration of Cases. 3 P. M.: Papers.

Saturday, August 8th.—9 A. M.: Clinical Demonstration of Cases, followed by papers.

Note.—The congress has been fortunate enough to secure for its use the building known as Examination Hall, on the Victoria Embankment. This will afford every facility for all kinds of demonstrations, cases, pictures, museum, etc. Special efforts are being made to have large clinical demonstrations of cases, and all who have been in London know how rich is the material there.

It is of the greatest importance that those intending to join the congress should notify the secretary, Dr. J. J. Pringle, 23 Lower Seymour Street, London, W., of their intention as soon as possible. The membership fee is five dollars, which should be sent in the form of a one-pound sterling draft on London, or post-office order to the same amount.

DR. GEORGE THOMAS JACKSON, 14 East 31st Street, New York,
Secretary for the United States.

JOURNAL OF
CUTANEOUS AND GENITO-URINARY
DISEASES.

VOL. XIV. MAY, 1896. No. 5.

Original Communications.

IMPETIGO CONTAGIOSA ANNULATA ET SERPIGINOSA.

BY JAY F. SCHAMBERG, A. B., M. D.,
Dermatologist to the Union Mission Hospital; Instructor in Skin Diseases, Philadelphia Polyclinic.

IN Rayer's *Atlas of Skin Diseases* * published in Paris, in 1835, are two plates representing impetigo annulata.

The term "pustular ringworm" is added in parenthesis. In the descriptive text Rayer says:

"Impetigo is characterized by small, inflamed, yellowish pustules; by honeylike crusts when the lesions are recent, and grayish or greenish ones like old plaster when the lesions are old. Sometimes impetigo exhibits certain peculiar appearances: *impetigo scabida* when the crusts are grayish, lamellar, and occupy a large portion or the whole of an extremity; *pustular ringworm* when the crusts are arranged in an annular manner."

The conclusion that the above illustrations are not those of pustular ringworm is, I believe, justified by the fact (1) that Rayer applied this term indiscriminately to crusts arranged annularly; (2) that the disease occurred in an adult female; and (3) that profuse crusting and high-grade inflammatory reaction were present.

A search of the literature in the more modern text-books of skin diseases gives us but little information in reference to this interesting form of impetigo. The treatises on dermatology in the English lan-

* *Atlas des maladies de la peau.* Par P. Rayer, médecin consultant du roi, médecin de l'hôpital de la Charité, chevalier de la Légion d'honneur, membre des Académies royales de médecine de Paris et de Madrid. Publié par J. B. Baillière, Paris, 1835.

guage contain nothing on the subject. The same may be said of most of the French works. Kaposi, in speaking of impetigo, says:

"Impetigo faciei contagiosa is characterized by the acute outbreak of pinhead to lentil-seed sized superficially seated vesicles in the region of the face, scalp, and neck. These appear in crops, discrete at first, later coalescing and drying rapidly to gumlike crusts, under which epithelial regeneration takes place. Some reach the size of a thaler in the form of concentric rings of vesicles resembling *herpes tonsurans* or *pemphigus serpiginosus*." Unna, in his *Histopathologie der Hautkrankheiten*, says: "In contradistinction to impetigo vulgaris, *impetigo circinata* forms flat, thin crusts which spread peripherally and sink in the center. The following is a typical case of the latter in an elderly man: A. L. Eight days ago there appeared upon the nose, chin, forehead, cheeks, and beard an eruption of vesicles. The ma-

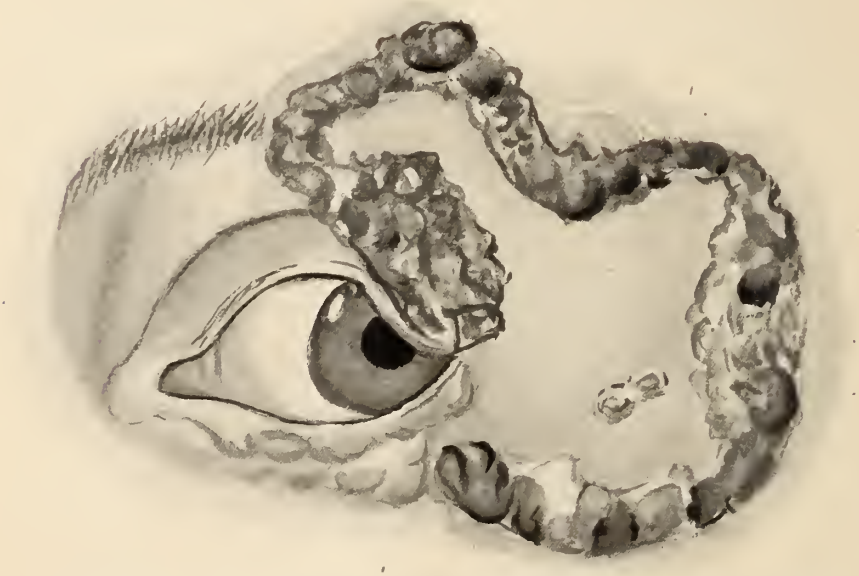


FIG. 1 (Plate VII of Rayer's Atlas).—"A variety of impetigo remarkable for the annular arrangement and the swelling of the skin under the crusts in an individual of strumous diathesis." Impetigo annulata (pustular ringworm).

jority of these were soon converted into brownish translucent crusts that spread peripherally, their centers becoming depressed and desquamating."

The arrangement of impetiginous vesicles in concentric rings, or in

a circinate manner at all, is certainly a rare occurrence in this country. From the descriptions of Kaposi and Unna, it would seem that



Fig. 2.—"Impetigo annulaire (pustular ringworm)" (Plate VII *bis* of Atlas). "This plate represents the crusts of impetigo arranged in irregular rings. This variety is very rare. The hairs between the crusts have been cut short. This affection developed in a woman who several months previously had a similar eruption around the left eye."

in Germany such an arrangement is not uncommon. The following case is, in my opinion, a remarkable instance of this unusual form of impetigo contagiosa:

B. K., a lad of ten years, presents upon the face, near the angle of the mouth, several pea sized pustules covered with profuse crusts. Upon the lateral and posterior aspects of the neck are similar though larger lesions, and also a few vesico-pustules. The axillary and pubic regions are the seats of a most remarkable condition. In the axillæ are symmetrically arranged gyrate patches the size of the palm of the hand, the centers of which are almost but not entirely clear. The border is serpiginous and made up of yellowish-brown, greasy, loosely attached crusts, which project a quarter of an inch above the surface of the skin. Large fragments of crust hang here and there from the border as if attached but by a thread. The centers of the patches show a number of round, crusted lesions, such as are seen upon the neck. The skin is not perceptibly reddened except when the crusts are removed. No ulceration is present. A large plaque the shape of a butterfly, the penis representing the body, involves the pubic and inguinal regions and the inner sides of the thighs. The crusts upon the borders are here even more prominent than in the axillæ. Upon the upper

part of the right thigh is a round patch about one inch in diameter, which shows distinct concentric crusting, as in rupia. The falling out of the central crusts would, of course, produce a typical circinate plaque. Other lesions are present upon the arms, neck, and back.



FIG. 3.

The accompanying photograph (Fig. 3), although an excellent one, might suggest to some an affection other than impetigo contagiosa. The involvement in this manner of the axillæ and pubis certainly con-

jures up the arrangement of eczema marginatum. The configuration of the patches and their localization are, however, the only points of similarity. Microscopical examination of the crusts proved the absence of any fungous elements. The pubic patch, with the outlying rupialike crust, might suggest the possibility of syphilis. Examination of the case clinically would have shown that the dermatosis was exceedingly superficial. The crusts lay upon the skin. There was no infiltration and no ulceration. It is scarcely necessary to repudiate the diagnosis of tinea favosa. It might be here added that the affected regions were in this individual still hairless.

That this case is one of impetigo contagiosa is, I think, beyond reasonable doubt. The long duration (eight weeks) and the extensive involvement are, I believe, due to the unusual activity of the exciting organism. It is more than probable that future research will discover a number of varieties of impetigo contagiosa produced by different bacteria. Unna to-day recognizes an "impetigo staphylogenes," an "impetigo streptogenes," etc.

Microscopic examination of the crusts showed the presence of micrococci, most of them in groups of twos. The pus from an unruptured vesico-pustule gave a similar result.

Under the use of an ointment of red oxide of mercury and white precipitate the affection rapidly improved. The patient was on the road to recovery when he disappeared from observation.

THE MANAGEMENT OF FILIFORM STRICTURE OF THE URETHRA, WITH SOME OBSERVATIONS ON STRICTURE.*

By J. D. THOMAS, M. D.,

Professor of Genito-Urinary and Venereal Diseases, Western Pennsylvania Medical College, Medical Department Western University of Pennsylvania.

IN order to be thoroughly understood, I premise by stating that I am in the habit of designating strictures as ones of large caliber, ones of medium caliber, ones of small caliber, ones of filiform caliber, and those that are impassable. By large caliber, I mean strictures measuring twenty-six millimetres in diameter and above; by medium caliber, those measuring fourteen millimetres and up to twenty-six millimetres; by small caliber, those measuring less than fourteen millimetres; by filiform caliber, those that will admit a fili-

* Read before the South Side, Pittsburg, Medical Society, January 6, 1896.

form only; and by impassable, those demanding perineal section without a guide. As a rule, all strictures below No. 14 F. must be treated with flexible instruments.

The ideal treatment of filiform strictures is by perineal urethrotomy, for nearly all strictures of this nature are found posterior to the scrotum, and as far back as the bulbo-membranous junction. If strictures are found anterior to the region mentioned—and as a rule they are—internal urethrotomy should be practiced at the same time. These strictures can, however, be successfully treated, in the great majority of cases, without the cutting operation, and the most of them must be so treated, as patients will not always submit to the cutting operation —only as a *dernier ressort.*

I beg leave to present for your consideration and criticism two cases taken from my case book, and which will serve as types for the lines of treatment which will be advocated in this paper.

Case I.—December 11th, Mr. A., aged thirty-three years. When a boy, nine years old, had retention of urine; says meatus was cut for this trouble. He then went along without any difficulty until he was twenty-four years of age, when he received a severe and dangerous burn, but the genitals were not involved. During this time he was again taken with retention of urine, and the catheter was used every day, not without difficulty, however, for it was frequently followed by some bleeding. It was said that there were then strictures, and the patient has used a catheter ever since, in "order to keep the strictures open." The size of the catheter has been gradually lessened, until at present he uses the smallest (No. 5 F.) made. The frequent catheterization probably accounts for the condition found. Several days ago, when he took up his catheter, he found that half an inch of the point was missing, and he believes that it is in his urethra; notwithstanding, he is able to pass a similar instrument. On examination, under ether, I find that the circumference of the penis is two and seven eighths inches, and a No. 8 F. bulb is the largest that will enter the meatus; this passes down five inches and a half and stops. As the bulb is withdrawn, the entire canal appears to be lined with rigid irregularities. After a somewhat prolonged trial, I failed to pass even a filiform through the deepest stricture. Further attempts are discontinued to-day, as the only alternative is to enter the bladder without a guide; and, as the patient is able himself to pass a small instrument, which would serve as a guide, the operation is deferred in order to secure that assistance.

December 15th.—Before etherization the patient passed on himself his No. 5 F. flexible instrument. After anæsthesia, I cut down upon

the instrument through the perinæum and came upon the lost piece of catheter, which I removed. I then passed a small director through the stricture and into the bladder and cut the urethra on this. The director was now removed and the floor of the urethra from the meatus to the opening in the perinæum cut with a Maisonneuve urethrotome; then the dilating urethrotome was passed in the same manner, opened to 28 F., and the roof of the pendulous urethra cut in its entire length. The urethra was then thoroughly irrigated and a No. 28 sound passed into the bladder. The patient left the hospital on January 1st. In the meantime a sound was passed every third day.

Case II.—Mr. B., aged thirty-six. Eight years ago had what was pronounced "catarrh of the bladder," which lasted only ten days. Four years ago had a discharge from the penis which lasted three weeks. This discharge was accompanied with ardor urinæ; there was also œdema of the penis. A few weeks after this he had retention of urine. One year later, after riding horseback, again had retention. About eight months ago had his last retention. These retentions were relieved by anodynes, poultices, and baths. On all these occasions of retention attempts were made to relieve him with instruments, but always without success. During all this time he has been troubled with frequent and difficult urinations. At the present time he is obliged to urinate every half hour, and then the urine only dribbles away. Examination shows a penis with a circumference of three inches and an eighth. Meatus admits a 28 bulb, which stops immediately. No. 22 stops at five inches and a half. After some effort a filiform is passed through this, then over this a Thompson's (tunneled) divulsor is passed, opened up, removed, and a No. 20 sound passed into the bladder. After the operation, done in the office and without anæsthesia, the patient went to his home, ten miles out of the city. In three days he returned and stated that he felt well and was only passing his water four times a day. After this gradual dilatation was practiced until a 32 sound was passed without much difficulty. This operation was done four years ago. The patient still calls at my office occasionally to see if any recontraction is taking place. I passed a No. 32 on him on November 2, 1895, over two months ago.

These cases are sometimes treated by continuous dilatation—that is, after the filiform is passed it is tied in and is permitted to remain for twenty-four hours. By this time the margin of the strictnre becomes softened and permits the introduction of a larger instrument. During the time that the instrument is *in situ* the urine is gradually drained away by capillary attraction. In this, however, we may meet with disappointment. During the period of continuous dilatation the

patient is required to remain in bed. After a certain amount of dilatation is secured in this manner, the further treatment may be conducted by the usual method of gradual dilatation. At other times they are treated by passing the smallest tunneled metallic instrument over the filiform that has been previously introduced. This tunneled instrument is removed, when another a size larger takes its place. This is repeated until sufficient room is secured to pass a soft catheter that has a caliber sufficiently large to permit the urine to discharge. This catheter is usually tied in for a period, after which gradual dilatation is practiced. It often happens in these cases—the most simple ones—that, as soon as the filiform passes, it may be immediately removed and soft instruments passed in succession up to No. 8 F. at the first sitting, which leaves the stricture in condition for gradual dilatation. If a great deal of trouble is experienced in passing the filiform, it is not always good practice to follow the last suggestion, for the reason that we may fail in reintroducing the filiform.

You will observe that in Case II, after passing the filiform, I passed down over it a tunneled Thompson's divulsor, and divulsed up to No. 20 F., and immediately passed a No. 20 sound, in order to smooth out the part divulsed, after which gradual dilatation was practiced. It is to emphasize this method of treatment that I have been induced to bring before you this subject. Lately most genito-urinary surgeons decry this method and call it unsurgical; to this I offer my earnest protest, so far as the perineal urethra is concerned. Let us first consider the method by continuous dilatation. To permit the instrument to remain, frequently causes continual pain as long as it is in the urethra, and this pain is sometimes so severe that in a short time it is forced out and the object of treatment nullified. If it does remain, it does not always act as a drain, hence some other method must be resorted to, to relieve the bladder. If it produces rigors it must be removed. It also confines the patient to bed. This last objection is not a serious one, but it is a factor.

Next, the method of passing tunneled metallic instruments, three or four in succession and in increasing sizes, at one sitting over the filiform. Where the stricture is so tight as to require this treatment, what occurs? It is probable that the first instrument with its point denudes a part of the urethra of its mucous membrane, and as the instrument is pushed forward some divulsion of the stricture takes place. Now, with the introduction of the next tunneled instrument, which is larger, a little more tearing and a little more divulsion take place, and so on to the end. This is followed by tying in a catheter, which, under the circumstances, is a dangerous proceeding. As the patient is not under an

anæsthetic, the operation of repeated introduction and removal of the tunneled sound requires time, and the patient necessarily suffers much more pain than with one introduction and one divulsion. The method I advocate has been, in my hands, absolutely safe. I have performed it in my office many times, permitting the patients to go to their homes —some of them living out of the city and traveling on trains. I have several times performed it before my class at the Western Pennsylvania Medical College from among the outdoor patients, the patients immediately returning to their homes. I have never experienced any untoward results and the hæmorrhage has been insignificant. The immediate relief experienced by the patients in their ability to urinate in a good stream and without straining makes it a most satisfactory operation. After the divulsion gradual dilatation is practiced until the full caliber of the urethra is reached. I do not mean to say that very satisfactory results are not got from the other methods, for I have practiced them myself, but with the divulsion method the operation is quickly done, the relief prompt, the danger *less*, and the patient's time is conserved. In all these cases the treatment should be continued until the full caliber of the urethra is reached and a full-sized sound passed at long intervals until the tendency to recontraction ceases. You may ask, "What do I consider the full caliber of the urethra?" I answer: That is to be determined for each patient by correct measurement. Sir Henry Thompson used to teach that if he could pass a No. 16 F. sound there was no stricture. Some will tell you that if they can pass a 26 F. sound there is no stricture. Such teaching is mere guess-work and unscientific. If I were to say that if I could pass a No. 34 F. sound there was no stricture, my teaching would be just as absurd. Dr. Otis, the elder, in order to be able to treat each patient from the standpoint of that individual, resorted to the comparison by measurement of the circumference of the urethra with the circumference of the penis. This he did in hundreds of cases, and he found that they bore a nearly fixed relation one with the other—not exactly, but near enough for the purpose of forming a working basis. After the measurements of these hundreds of cases, when he had become sure of his premises, he made the results of his labors and investigations known. He found that a penis measuring three inches in circumference gave a urethral circumferential measurement of thirty millimetres, and for every eighth of an inch difference in the circumference of the penis there was a difference of one millimetre in the circumference of the urethra. These measurements were made with the tape-line and with his urethrometer, with which you are all acquainted. Some attempt to ridicule these measurements by the statement that it would be as

reasonable to estimate the caliber of the intestines by the girth of the abdomen, or the caliber of the œsophagus by the circumference of the neck. Have these comparative measurements ever been made? If not, their statement is puerile. Let me show you how ridiculous this ridicule is. We will take, for instance, two men, each six feet tall; one is lean, the other is fat. Which has the larger circumference around the abdomen? We will now measure the circumference of the penis in these men, and the probability is that we will find the larger penis on the lean man. It is a fact known to every medical man that the size of the body bears no relation to the size of the penis. I have, myself, examined hundreds of cases, with the idea of corroborating or refuting the observations of Dr. Otis, and the result has been to corroborate the measurements as laid down by him; indeed, I found a greater number of urethræ going above his mark than below. My method in examining the urethra is as follows: After passing the closed urethrometer to the bulbous portion, it is opened to the proper size as ascertained by the circumferential measurement, and gently drawn forward to the meatus. It is then gently passed back again. By this manœuvre I am informed whether it fits the urethra *comfortably* or not. If it slides to and fro too easily, I open it another millimetre, more or less, and thus get the exact caliber of each urethra. Some say if you turn the bulb on "strongly enough," you can find a stricture in any urethra; yes, and if you turn it on still stronger, you can not budge it. But an expert would never use the instrument in that way. You may ask, "How do you provide for the normal narrowings of the urethra?" Sir Charles Bell said that a stricture was "any loss of dilatability of the urethra." Now, in bringing forward your meter at the proper size, you are able by your *tactus eruditus* to detect these points by a slight resistance, but the urethra has not lost its dilatability, and the mucous membrane gives at these points, the meatus not included, a sensation which indicates their existence, but does not prevent the bringing forward of the instrument. In scores of cases you can not detect these normal narrowings at all. If there is a stricture, the result of an inflammatory exudate, the urethrometer comes "chuck" against this, and you can not advance it, and the sensation conveyed to the hand reveals very readily the fact that there is a stricture—the dilatability is wanting. I do not open the urethrometer in the bulbous portion until a sense of fullness is experienced, as recommended by Otis, for it often happens that before this sensation is felt the meter may be opened several sizes too large. In a urethra whose caliber is 30 F. I have opened the meter in the bulbous portion to 40 F. without producing any discomfort. The normal dilatability of the bulbous portion is great as

compared with the remainder of the anterior urethra, for it serves, during urination, as a governing reservoir, regulating the column of urine that passes through the urethra; on the same principle that the governor of an engine regulates the amount of steam admitted into the cylinder. When the membranous urethra opens and the powerful muscles of the bladder contract during urination, with an ordinary full bladder, an irritation of the meatus, which is the narrowest part, would be set up by the powerful stream being impinged against it; but this is avoided by the regulating function of the bulb, surrounded as it is by the strong accelerator (bulbo-cavernous) muscle, which expands and contracts—expands, yields, with the contraction of the bladder muscles and contracts with the expanding, yielding, of the bladder muscles. Hence a comparatively uniform stream passes along the penile urethra.

It has become the fad among recent authors to overdilate on overdilatation of the strictured urethra. It appears to me that one copies from the other until it has become monotonous—a mutual admiration, as it were. But to show how they disagree among each other, allow me to make a few quotations. Hyde and Montgomery, in their *Manual*, "adopt a scale from four to eight sizes smaller" than Otis. J. William White, in his article in *Genito-Urinary Diseases* by Morrow, says "four millimetres lower" than Otis. Taylor, in his recent work, says: "If stricture is really present, it should be treated on the basis of the maximum caliber of the urethra being 30 F., or perhaps 32 F." Gouley says, speaking of the treatment of a case of stricture, "On the eighth day, No. 14 (No. 24 F.), which has since been introduced every fourth day." Sir Henry Thompson says: "Whatever, then, a man may tell you, and however small the stream may be, take an instrument not less than No. 8 or No. 9 (15 or 17 F.), pass it gently down the canal, and if there is a stricture the instrument will be arrested." Keyes, referring to the Otis standard, says: "That these sizes may be safely attained, the long experience of Dr. Otis proves. That they are generally necessary, I, personally, am not convinced. That they may sometimes be desirable, I believe."

It appears to me that all the authors quoted, Keyes excepted, adopt inflexible rules, relegating to no man a urethra (with some) larger in caliber than No. 17 F. or (with others) 30 F. The fact is that those who accuse Otis—who recognized no standard, but measured the urethra of every patient requiring treatment—of giving patients urethras of preconceived calibers are themselves the ones who are culpable. One author says: "Exploration of the urethra . . . should be begun by the introduction of a blunt steel sound of the largest size

that will pass the meatus. As a rule, if such an instrument pass easily into the bladder, stricture is absent." Do all males have a uniform relation between the meatus and the urethra back of it? The same authority says: "The diagnosis of stricture should then be reserved for a distinct contraction of the urethra, accompanied by a gleety discharge, frequent micturition, dribbling of the urine after urination, and other symptoms of stricture." A genito-urinary surgeon ought to diagnosticate urethral stricture before such serious symptoms are experienced by the patient. Strictures are always first ones of large caliber; then, if untreated, in time become ones of small caliber. Is it not scientific, then, to treat them as soon as they become strictures? If we follow the teaching of some, we must not recognize them until they fit a sound anywhere (depending on who the doctor is) from No. 17 to No. 30 F. We all know that it is seldom necessary to pass sounds unless it is for the treatment of strictures, and it is trifling with the patient to half cure him, and he is only half cured when he is dismissed with a ring, regular or irregular, of organized or agonizing exudate surrounding his urethra, and which is four or six millimetres less in circumference than the mucous membrane behind and in front of it.

77 and 79 South Thirteenth Street.

EPICYSTOTOMY AND USE OF THE HARD RUBBER STEM IN THE TREATMENT OF "OLD MAN'S BLADDER."*

By W. O. ROBERTS, M. D.,

Professor of Surgery and Clinical Surgery in the University of Louisville; Member of the Louisville Surgical and Louisville Clinical Societies, etc., Louisville, Ky.

THE latter part of November, 1895, a gentleman, aged sixty-eight years, came here to consult me from Shelby County, Kentucky. The history was that he suffered from inflammation of the bladder, and upon examination I found that he had a stone. The case is interesting from the fact that two years ago this same patient applied to me for treatment with a piece of catheter in his bladder. He had been forced to use a catheter to withdraw his urine every time he went on a spree. The intervals between his sprees varied from a week or two to several months. He had not used a catheter for three months, having kept it in a drawer, and when he introduced it into his bladder

* Reported to the Louisville Clinical Society.

and attempted to withdraw it the catheter broke and a portion of it remained in the bladder. When I saw him, three weeks later, I did a suprapubic cystotomy, removing a piece of catheter two inches in length, very thickly incrusted with phosphates. The opening remained patulous for several months, and, as nothing was done to keep it open, it gradually closed.

About four months, he says, prior to his last visit to me, he began suffering from bladder symptoms again, which steadily increased, and when he came here he was passing his water every half hour, suffering intense pain all the time. I made an incision through the old cicatrix down to the bladder and removed this stone, which you will observe is about the size of a guinea-hen's egg. I drilled a hole through the center of the stone to see whether it contained any particle of catheter which might have formed a nucleus for the formation of the calculus, but could discover nothing.

Shortly before operating upon the case just reported, another gentleman consulted me from whom I had removed three stones three years previously; one of them was adherent to the walls of the bladder, the other two were loose. This man was operated upon in the same manner by the high method, and nothing was done to keep the wound patulous. It gradually closed, and he went on using the catheter, being unable to void his urine in the natural way. Less than a year after the first operation I had to operate upon him again, and at this time I removed, it seems to me, a half-glassful of soft calculi, which were presented at the time before this society. I then kept a stem in his bladder, and when he wanted to urinate he would simply withdraw the stem and the water would pass out through the fistulous tract. Through a tube introduced into the same opening, his bladder was washed out daily by his nurse. This last operation was done last April. During the month of August he passed several small stones, about the size of an ordinary army bean. Three or four weeks ago he still complained of bladder symptoms, and I advised him to have the opening enlarged, so that I could again examine the bladder. This was done by simply slightly enlarging the external wound, and, introducing my finger, I dilated the opening in the bladder and removed seven stones, which I exhibit for your inspection. They are each about the size of the first joint of my little finger. One of these stones was deeply imbedded in a pocket in the posterior wall of the bladder. It was so deeply imbedded that I had considerable difficulty in detaching it. It was finally removed, and I inserted a much larger tube than the one he had been wearing, the one previously worn being about the size of a lead pencil. The one now being worn is about as

large as my thumb. His bladder is washed out daily through this tube. I have been very much afraid, on account of the size of the opening, that he would have prolapse of the bladder, but such a complication has not yet occurred.

Since operating upon the cases already reported I have operated upon two others, not for stone, but for the relief of cystitis following catheter life. One gentleman is eighty-one years of age, and wears a tube similar to that in the case just reported. Four days ago I operated upon a gentleman from Mount Sterling, Ky., who is seventy years of age, by the same method, and he has got along without any trouble whatsoever. He was brought to consult me by a patient who was referred to me by Dr. Palmer. I operated upon him, and found a small tumor, a valvelike arrangement, which completely closed the neck of the bladder. He was unable to pass his water for four months before coming here. After removal of the tumor he was able to urinate in the natural way, never had to use a catheter, and could throw a stream two feet from his penis.

DISCUSSION.

DR. I. N. BLOOM: Those who do surgery in the line mentioned by Dr. Roberts can appreciate the importance of his remarks. I had the pleasure of seeing the last case mentioned. The man was quite voluble, and entered into frequent explanations during the course of our examination. He said that before the operation he was unable to hold his water more than a half hour, but since the operation he was able to hold it four, five, and six hours without trouble. The contrivance Dr. Roberts referred to is simply a perforated stem with a stopper in the shape of a bandage which is easily adjusted by the patient, and he can empty his bladder with comparative ease. The doctor's remarks are of especial importance in connection with a class of cases which we all see, and which generally pass along until sooner or later they fall into the hands of the specialist. I refer to cases of enlarged prostate and want of tonicity of the bladder walls, that condition in which the patient has reached the extreme degree, so that catheterization with its attendant evils becomes a necessity. Many of these cases are operated upon by drainage through the perinæum, in the hope that rest of the bladder will cause sufficient tonicity of the bladder walls to allow the patient to finally void his urine *per vias naturales*. We know that success in such instances is one of the greatest of rarities. Further, by making an opening through the perinæum which is kept patulous for four or five months, allowing rest of the bladder for this length of time, then allowing the wound to heal, we have a double danger

imposed—chronic catheterization of the bladder where more or less enlargement of the prostate exists, and the increased tendency to calculous formations. The method mentioned by Dr. Roberts is not only an improvement in the general sense over other procedures recommended for operating for stone, but it is an improvement that makes us think of doing the operation in aged cases of enlarged prostate where catheterization has become necessary. It is a question whether it would not be better to perform this operation with the stem, as suggested by the doctor, than to allow our patients to continue the use of the catheter. I remember listening with a great deal of interest to Dr. Yandell when he gave his experiences many years before bacteriology was thought of. The point which particularly impressed me was the case he related of a man who was compelled to use a catheter and was in the habit of carrying it about in his pocket, or, more correctly speaking, first in one pocket then another; the catheter was never washed or cleansed in any way after being used. Yet this man would void his urine through the catheter in an apparently pure stream, without any bacteria which we now so often find as a result of sepsis. Such instances we know do occur, without the assurance of Dr. Yandell, but they are rare. It is a serious thing for a man to catheterize himself on an average every two hours for three or four years. I believe the average in these cases is every hour. The question in my mind is, whether the procedure suggested by Dr. Roberts will not be the operation of the future; whether it is not indicated in cases where there is no stone, simply for relief of the conditions present. I am satisfied that the operation was indicated in several cases in which I refused to interfere, simply advising the patients to use a catheter. One case I remember I saw in Indiana some time since, another was recently seen in this State. Both cases were rather severe; the latter patient had to use the catheter every half hour when symptoms were most severe, and every hour at other times; but for obvious reasons I advised against any operative interference. If the patient applies to me again for advice, I shall recommend the procedure Dr. Roberts has described.

In this connection it seems a little strange that the operation of litholapaxy has not become more popular in this country. Certainly we have many surgeons in Louisville who are capable of performing this operation, though we must admit that it requires no small amount of skill and delicacy of touch to be able to detect with the lithotrite and crush the fragments of stone in order to be sure that the bladder has been perfectly emptied. I have performed the operation many times upon the cadaver, and upon opening the bladder afterward found

its mucous membrane intact, with every particle of stone crushed, showing that had the operation been upon the living subject success would have been assured. On the living I have performed it but once, and that successfully. Litholapaxy is certainly the ideal operation, and there are few stones where its use is contraindicated. In skillful hands the mortality is much less than by other methods; recovery is much quicker, and there is no open wound to repair. I do not see why the fact of great skill being required should prevent the surgeons of the South and West from practicing this method. We surely do not yield the palm in this respect to those of the East.

There is one other point of interest in Dr. Roberts's cases of recurrent calculus of which I wish to speak. A patient is operated on for stone by one of the various methods. The stone is extracted and the patient gets well. Too often this ends the case as far as the surgeon is concerned. It should not. A vigorous and long-continued antilithiasis treatment should be given, and I am satisfied that if this were done there would be fewer cases of recurrence of calculi. Sir Henry Thomson's regimen of Friederichshall and Carlsbad waters, together with alkalies, bicarbonate of sodium, potassium and lithium carbonate, should be administered for at least a year after the operation.

DR. W. C. DUGAN: I was very glad to hear Dr. Roberts make the point of early operative interference in cases of the character under discussion. We should operate early and not wait until it becomes an operation of necessity, but make it an operation of election. I know I have made mistakes in operating upon such cases after cystitis had developed, where the trouble had become far advanced, the patients having more or less delirium, etc. Epicystotomy under such conditions is usually fatal—that is to say, the patients usually die, not from the effects of the operation, but because the trouble has so far advanced that we can not hope for a successful result from surgical means. Instead of waiting for all these symptoms to develop, we should resort to early operative measures.

Dr. J. D. S. Davis, of Birmingham, Ala., has done more to popularize this operation than any one else, I am sure.

As to the use of the tube, I hardly agree with the previous speakers in this respect. If there is more or less contraction of the bladder, then the tube is a necessity; but where this condition does not exist, we can make the procedure a cystostomy, stitching the bladder to the abdominal wall, thus doing away with the use of the tube entirely, or simply use it as a means of preventing the wound from closing.

In regard to the crushing operation: In the hands of the ordinary surgeon, I believe that epicystotomy or median cystotomy is far safer.

The operation of litholapaxy is certainly a dangerous one in the hands of the average surgeon: first, from injury to the bladder; second, their inability to detect the small fragments that require such great skill and delicacy of touch to be able to detect. I think, therefore, that the operation will always remain in the hands of the few skilled surgeons who possess extraordinary ability and make litholapaxy a specialty. I could not produce stronger argument against the operation than to use Dr. Bloom's own words, "that delicacy of touch and manipulative skill" but few naturally possess and still fewer ever acquire.

Certainly in the class of cases reported by Dr. Roberts where the stone is the result of decomposed urine brought about primarily by an enlarged prostate, and later, and as a result of this enlargement, cystitis, the removal of the same by the method advised by Dr. Bloom is illogical. The removal of the stone is of secondary importance to drainage, since it is the effect and not the cause of the trouble. Then, again, I would like to call attention to the condition of the bladder with enlargement of the center lobe of the prostate resulting in a deep fossa, the bottom of which can not be reached with the lithotrite. Then I would say for three reasons I would advise against the operation in such cases: first, it is impracticable to reach that part of the bladder behind the prostate, and therefore the operation would of necessity be incomplete; second, the stone is the result of an old cystitis, and if removed another would rapidly form without first relieving it; and, third, it is far more important as to the future of the patient that permanent drainage be secured by cystotomy.

Dr. W. O. Roberts: I have only a few words to say in closing the discussion: If the tube is used until the bladder contracts sufficiently, it will enable us to use the stem successfully; then the tube is not necessary except when the patient fails to empty his bladder by withdrawing the stem.

EPITHELIOMA OF THE PENIS.*

By WILLIAM L. RODMAN, A. M., M. D.,
Professor of Surgery and Clinical Surgery in the Kentucky School of Medicine; Surgeon to the Kentucky School of Medicine Hospital, the Sts. Mary and Elizabeth Hospital, etc., Louisville, Ky.

THIS gentleman, aged forty-three years, was operated upon eighteen months ago for epithelioma of the penis. Dr. Weidner will remember the case. He assisted me in the operation; also made a microscopic examination. It was reported as an undoubted

* Reported to the Louisville Clinical Society.

epithelioma, and had that appearance clinically, so I was not at all surprised at the statement made by the microscopist.

My advice to the patient was to amputate the penis, but he declined this, and wanted something less radical done at first. I applied Michel's paste, first scraping away a great deal of the neoplasm. There were no enlarged glands at the time. Fortunately, the neoplasm was on top of the penis, and for this reason I had no fear of the caustic injuring the urethra. You will observe the result has been perfect in every respect. This is not the only successful case of malignant disease treated by caustics in my hands; I now have the records of a reasonable number of patients who have, I believe, been permanently cured. The case shown to-night was presented to the Surgical Society before operation, and was pronounced by every one to be malignant. Dr. Bloom, who was then present, will remember the case. The most capable microscopist I know of confirmed this diagnosis. While it is true that he has not passed the three-year limit, I believe he will pass it and never more be troubled.

A MODIFIED RECTAL COOLING SOUND FOR THE TREATMENT OF PROSTATITIS.

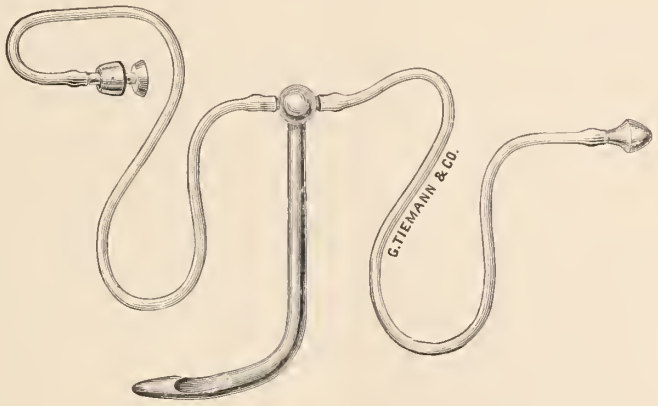
BY HERMANN GOLDENBERG, M. D.,
New York.

IN presenting this instrument, which the writer has been using for the past few months, he does not claim it to be an original or new apparatus, but simply desires to introduce it in an improved form as an instrument which is not well enough known nor sufficiently appreciated as a therapeutic aid in acute or chronic inflammations of the prostate gland and seminal vesicles.

The original Arzberger's hæmorrhoidal apparatus has proved to be a very valuable instrument in the treatment of prostatitis the last seven years during which the writer has been using it, and he attributes to the early use of this instrument the fact that not one single case went on to suppuration. Nevertheless, he has met with cases of considerable enlargement of the prostate gland, especially of an acute character, where the cooling sound could only be introduced into the rectum with great difficulty and with much inconvenience to the patient.

This difficulty was due to the shape of the instrument—being a straight tube, and the tip of the latter being too large in circumference, and not in accordance with the anatomical condition of the prostate

gland. In the modified form the instrument is curved at an angle of a little over ninety degrees, the length of the beak being three and a half to four inches—sufficiently long to reach the prostate gland and seminal vesicles. As the instrument does not possess any other new features, instead of a more detailed description the writer refers to the accompanying cut. The makers of this cooling sound are Messrs. G. Tiemann & Co.



The patient, either in the recumbent position or while sitting on the edge of a chair, can introduce the instrument with ease, since it is curved and has a long handle. When *in situ*, it is not uncomfortable to the patient, not even in acute cases. In the latter the protracted use of iced water is indicated; in chronic cases the writer prefers water as hot as the patient can stand.

By gently moving the instrument in the proper direction a massage of the prostate gland or seminal vesicles can be obtained; but the writer considers the touch of the finger more reliable and effectual for that purpose.

Society Transactions.

THE NEW YORK DERMATOLOGICAL SOCIETY.

250TH REGULAR MEETING, HELD ON TUESDAY EVENING, FEBRUARY 25, 1896.

DR. C. W. CUTLER, *President, in the Chair.*

A Case of Papulo-tubercular Syphilide of the Lower Legs.—Presented by DR. KLOTZ.

The patient was a man, thirty-five years old, a swimming master by occupation. On the front aspect of the left leg he presented a large patch of a moderately infiltrated, smooth, dark-red (ham-colored) skin, with irregular, somewhat scalloped outlines, showing some pigmentation, and in some places slight cicatrization. Several smaller patches were found scattered on the left leg and on the right leg above the malleolus externus. There was no clear history of syphilis. The patient denied having had a chancre, but admitted a general eruption about seven years ago. The present eruption began about eight months ago, and besides rubbing with alcohol had received no treatment. There is comparatively very little infiltration for a syphilitic affection of so long duration; the large patch greatly resembles psoriasis.

DR. FORDYCE pronounced the eruption a papulo-squamous syphilide.

DR. FOX and SHERWELL also regarded the lesions as syphilitic. DR. BRONSON made a similar diagnosis.

DR. LUSTGARTEN thought the eruption belonged to tertiary syphilis, with some of the characteristics of secondary lesions. It is similar to what the French call tertiary papules.

DR. R. W. TAYLOR thought there were hardly sufficient data upon which to base a diagnosis of syphilis. During the past summer the man was engaged as a life-saver at a bathing resort, where his legs were constantly exposed to irritation by the salt water, sunburn, etc., and the skin might easily have become infected and inflamed.

DR. FOX said the man had had no subjective symptoms. On the right leg there were a number of softened tubercles which in appearance were decidedly characteristic of syphilis.

DR. C. W. ALLEN also regarded the lesions as syphilitic. The slight eczematous condition present was probably secondary.

Report of Cases presented at Previous Meetings.—DR. LUSTGARTEN said that at the last meeting he presented a young girl with peculiar lesions in the mouth. He put the patient on arsenic, but up to the present time the lesions have not undergone much change. The microscope showed that the tumors were papillomatous in character. There was hypertrophy of the derma, with slight inflammatory changes and increased cellular infiltration. No adenomatous tissue could be found.

DR. FOX reported that his case of lichen scrofulosorum was practically unchanged.

Dr. Fordyce stated that at the last meeting he presented a woman with a lesion on the left cheek. A few days afterward he curetted the lesion and found that the infiltration consisted principally of extravasated blood; there was no real pigmentation. Since the curetting there has been no recurrence.

Dr. Sherwell reported that in his case of sarcoma of the ear, presented at the last meeting, a radical operation had been performed by Dr. G. R. Fowler. The microscope showed that the growth was a melano-fibro-sarcoma. The glands in the neck had also been removed, and specimens had been sent to Drs. Fordyce and Robinson for examination.

Dr. Fordyce stated that he had not yet completed the microscopical examination. The glands appear to be studded with small pigmented points, due to metastasis.

Dr. Jackson said that several months ago he presented a case of scleroderma in a baby. The child is alive at the present time, and his skin is clearing up. His health is apparently first class.

Dr. Lustgarten reported that his case of pityriasis rubra pilaris in a boy twelve years old, which he presented at the January meeting, was still under observation. He is at present giving him carbolic acid internally. Large doses of potassium iodide had no effect on the eruption.

Dr. Fox reported that about a year ago he showed a case of favus of the body in a young man. The lesions on one side of the body were treated with mercurial plaster, and those on the other with salicylic acid. Both methods proved effective, and when the patient left the hospital he was apparently well. He left the city and went to Boston, where he remained for six or eight months. Recently he again appeared with an eruption of favus quite as extensive and in almost the exact localities occupied by the previous one.

Dr Cutler reported that his patient with alopecia areata following herpes zoster, whom he presented several months ago, had completely recovered.

Dr. Fox reported that his patient with an extensive lesion on the nose and upper lip, whom he had presented at the December (1895) meeting and again in January, had entirely recovered.

Dr. Klotz stated that he had recently seen again the boy presented at the October meeting, who, aged seventeen, besides symptoms of cretinism had an eczematous eruption on the thigh and abdomen. He had been in the German Hospital for some time and had again at different stages been treated with tablets of thyroid extract, but with no material effect. The former eruption had healed, but new lesions continued to appear on the upper regions of the body, without any provocation, certainly not in consequence of irritating applications. He expected that sooner or later the case would develop either in dermatitis desquamativa or pityriasis rubra, or into mycosis fungoides.

Dr. Jackson stated that he had at present under his observation a gynæcologist who, while operating on a syphilitic patient, inoculated himself, and a chancre developed on his right thumb, followed by a general eruption on the body. Thus far the course of the disease has been very severe. As the man is married and depends entirely upon his profession for a living, the important question arises, When can he operate again with safety to his patients? He would ask the opinion of the members as to the proper answer to this question. He had told him that he would, of course, be safest not to operate

for two years. But as that would not be practicable, he certainly should not operate as long as the chancre was on his thumb, or there was an eruption on his hands and arms.

DR. R. W. TAYLOR, in reply to Dr. Jackson's question, said that if the man followed out the letter of the law he would not operate again for eighteen months at least, for, although the blood is regarded as the least potent of the infectious vehicles of syphilis, statistics have shown that it is liable to be infectious a year and a half, two years, or even longer, after the initial lesion appears. Of course, when a man's bread and butter are dependent upon his work, this becomes a hardship. After the initial lesion on the finger and the eruption had entirely disappeared, he might begin to operate again, wearing a rubber finger-stall and exercising great care so as not to get a cut or abrasion on his hands. Several years ago Neisser wrote a paper on this subject which caused a good deal of discussion; in that paper he gave a number of instances where surgeons were said to have communicated syphilis after having had a chancre of the finger. Situated on the thumb, there is perhaps less danger of infection than on the forefinger, which is the one commonly employed in making vaginal examinations, etc. In a case like the one cited by Dr. Jackson, we must decide between sympathy and science. The disease should be treated as energetically as possible, and even after the chancre has healed the finger should be well protected, as in these cases the affected finger is apt to remain in a hyperæmic condition for a long time. After that he must be careful not to inoculate his patients by blood infection, of which a number of well-authenticated cases are on record. Although the danger of blood infection is small, still it is to be feared.

DR. SHERWELL inquired whether any of the members had seen cases of syphilis in which cerebral symptoms made their appearance within three months after the appearance of the initial lesion; he also inquired as to the value of potassium iodide during the early stages of virulent syphilis.

DR. TAYLOR said he had found that in cases where cephalalgia, neuralgia, pains in the muscles and joints, etc., appeared early in the course of the disease, potassium iodide, combined with mercury, was much more effective than mercury alone. In the lesions of tertiary syphilis, unless the disease is of very long standing, his best results have followed either inunctions of mercury—making the applications directly over the site of the lesions, or as near to them as possible, and at the same time giving potassium iodide internally —or injections of bichloride of mercury combined with the iodide.

DR. SHERWELL stated that cases had come under his observation in which he felt convinced that the too early and free use of potassium and other iodides was responsible for serious and even in some cases fatal results.

DR. FORDYCE said he had observed two cases of syphilis in which death was the result of excessive doses of the iodide. In one case, in which hæmorrhages from the bowels occurred, more than a thousand grains of the drug had been administered daily. He expressed the opinion that after we get beyond a certain dose, say two hundred and fifty grains, the surplus passes through the body without producing any effect.

DR. TAYLOR said he did not agree with the statement made by Dr. Fordyce that limited doses of the iodide—that is, not above two hundred and fifty grains—produce the full effect of the drug. He recalled several cases in which much larger doses were necessary before the beneficial effects of the

drug were observed. When inunctions are used synchronously with the iodide, the latter exerts a greater potentiality, and it is not necessary to give it in such large doses.

Dr. Piffard said that over twenty years ago he first expressed the view that, in making applications of mercury in cases of syphilis, the nearer you come to the lesions you wish to relieve the quicker will relief follow; in other words, that mercury, in curing syphilis, does so purely by a local action, and not by any mysterious influence on the nutrition.

Dr. Taylor said perhaps Dr. Piffard would be pleased to hear of a case reported by Köbner, who ordered inunctions of mercury to remove a papular syphilide; the inunctions were accordingly made, only sparing a small area which was rather tender on account of its being the site of some molluscous growths: the papular syphilide promptly disappeared, excepting in the particular area where the inunctions had been omitted.

Dr. Lustgarten said he did not think there was any doubt about the local effect of mercury. This can be readily demonstrated by the application of mercurial plaster to a specific lesion. As long ago as 1860 Hebra pointed out the fact that after hypodermic injections of mercury the syphilitic lesions nearest to the point of injection are the first to disappear.

Dr. Piffard said he was fully convinced that excessively large doses of potassium iodide may prove harmful and even fatal if the kidneys are not in good condition, thus preventing free elimination. Mercury was eliminated by the kidneys very freely, and its presence in the urine could be readily detected by simple means.

Dr. Lustgarten stated that about four months ago a physician came under his observation with an initial lesion on the thumb. The case proved to be one of syphilis of the malignant, "galloping" type. He had a dense papular eruption, and complained of severe headaches, rheumatic pains, insomnia, and various nervous symptoms. As he was unable to bear local applications of mercury, the drug was given hypodermically. The lesions disappeared quite rapidly, but there were several relapses. About a fortnight ago he again developed intense headaches, followed by a transient monoplegia of one arm and aphasia. The injections of mercury were again commenced, and he was also put upon increasing doses of sodium iodide; while there has again been decided improvement, he still suffers from headaches, sleeplessness, and profound asthenia. The speaker said that, if other methods of treatment fail to effect an improvement in this case, he felt inclined to try the toxines of erysipelas. He asked the opinion of the other members regarding this step.

Dr. Taylor said he judged, from Dr. Lustgarten's description of the case, that the patient's general condition was very poor, and as the lesion is intracranial it is a question whether it would be good practice to subject him to the toxines of erysipelas. He had seen a number of patients who were supposed to possess an idiosyncrasy regarding the use of mercury or potassium iodide which was entirely overcome by persisting in the treatment The word idiosyncrasy is too much of a bugbear to the ordinary mind, and often makes us weaken too quickly.

Dr. Bronson suggested the use of very small doses of calomel (one twentieth of a grain) in cases where there is an intolerance to other forms of mercury.

Dr. Taylor said he had seen marvelous effects produced in cases of malig-

nant syphilis by the use of small doses of opium, given in the form of laudanum, two or three drops three times daily, in combination with the mixed treatment. He had seen this treatment benefit patients upon whom mercury seemed to have no effect. Several writers have also recently claimed good results from the use of thyroid extract.

DR. FRANK P. FOSTER said there was some experience on record in favor of some of the compounds of cantharidic acid given in combination with mercury to increase the action of the latter drug, and make the patient more tolerant of it. In regard to the use of the toxines of erysipelas in a case like the one described by Dr. Lustgarten, it would be entirely experimental, as, so far as he knew, no one had tried it. In a number of cases where accidental inoculation with erysipelas had occurred, the remedial effect had been reported as very rapid and thorough for the time being, but had not proved permanent, except in one case that had occurred in the experience of a Russian surgeon.

DR. LUSTGARTEN said that several cases of syphilis had been reported which were much benefited or cured by accidental erysipelas inoculation after legitimate treatment had failed.

DR. FOX said the tone of the discussion seemed to be based upon that most erroneous idea that a disease, whether it be syphilis or something else, must be treated by drugs. According to his experience and observation, syphilis occurring in a man with a good constitution and one who takes good care of himself will run its natural course and the patient will get well. The treatment of the patient is often of far more importance than the treatment of the disease, and the severe forms of syphilis which we often meet with are sometimes the result of excessive treatment rather than of the disease. We all understand the value of hygienic treatment, but we do not always insist on its being carried out. Some time ago, the speaker said, he presented to the society a woman who had large gummatous tumors upon the nose. She had had syphilitic lesions on other parts of the body, but these had disappeared under specific treatment. The growth on the nose had failed to yield to large doses of mercury and iodide. For this reason it was thought by some that there might be a tubercular element in the lesion. In this case the syphilitic treatment was stopped, and the woman was put on nutritious food, ordered to take regular outdoor exercise twice daily, etc. A marked improvement in her general condition was soon noticed, and in one month the syphilitic growth had entirely disappeared. This simply shows that there are cases which will not respond to the ordinary treatment if the patient is not in good general condition. No one, Dr. Fox said, has a higher appreciation of the value of mercury and potassium iodide in syphilis than he, but these remedies, valuable as they are, will do no good when given to a dead man, and very little if any when given to a patient who is poorly nourished, living indoors, and whose general condition is far below par. Under such conditions they ought not to be expected to produce the brilliant therapeutic results of which they are capable, and the greatest mistake commonly made in the treatment of syphilis, not to mention other diseases, is this sole reliance upon the effect of drugs.

DR. DANIEL LEWIS said that the case reported by Dr. Fox, in which improvement followed the use of mercury after all medication had been temporarily suspended, simply emphasized the force of the well-known principle

that a tolerance of drugs is easily established even in syphilis, and that we get better effects by intermitting the treatment from time to time. This rule applies not only to mercury, but to many other remedies.

Dr. Fox said he did not think the benefit in his case was entirely due to suspending the use of mercury temporarily, although that may have had something to do with it. The improvement, he thought, was chiefly due to her superior hygienic surroundings.

Dr. Taylor said he agreed with Dr. Fox in so far as his remarks applied to putting our patients into the best condition possible. Such a course is universally pursued. He differed with him entirely regarding the value of mercury in syphilis. Many cases of syphilis had come under his observation in which the expectant treatment produced the most deplorable results. He hoped that the old-time famous antimercurialistic ideas would no longer be entertained.

Dr. Lustgarten said that while it had long been known that somes cases of syphilis got well without the use of mercury or other specific medication, yet, on the other hand, we see far more frequently cases in which the disease has existed for years in spite of the most favorable hygienic surroundings, and which promptly improved under the use of mercury.

Dr. Klotz said, to judge from the effects in other than syphilitic affections, he would expect to see beneficial results follow the use of the toxines of erysipelas in the gummatous or ulcerative lesions of syphilis rather than in the early, diffuse lesions.

Dr. Allen said he had observed two cases in which gummatous lesions of the scalp were decidedly improved if not cured by the accidental inoculation with erysipelas.

THE NEW YORK ACADEMY OF MEDICINE.

Section on Genito-Urinary Surgery: Stated Meeting held on Tuesday Evening, March 10, 1896.

Dr. W. K. Otis, *Chairman.*

A Case of Urethroplasty Secondary to Perineal Section.—Presented by Dr. R. Guiteras.

The patient was a young man who, while working in a coal mine out West, was struck in the side by a falling rock and sustained a fracture of the pelvis and a rupture of his urethra. Twenty-four hours after the accident, as no urine had been passed, an ineffectual attempt was made to introduce a catheter. Perineal section was thereupon performed; a tube was inserted and left in for six days. The patient remained in bed for about two months, during which time he was unable to pass his urine through the perineal opening until after the passage of a sound. No urine was passed *per urethram*, and no instrument could be introduced into the bladder by that route. He again took up his work as a miner and continued it for two years, during which time the opening in the perinæum kept growing smaller. He then came to New York. An examination showed a small opening in the perinæum, about

midway between the scrotum and anus, through which he passed his urine with great difficulty. He urinated frequently, and with each act the straining required would be so great that a prolapse of the rectum would occur. It was found that the urethra was impermeable for an inch and a half anterior to the sinus. This was laid open by an incision, and a tube introduced into the perineal opening and left there for several days. A 30 French catheter was then introduced into the bladder through the anterior urethra and left there for six days. In order to close the fistula a secondary urethroplastic operation was performed. An elliptical incision was made on either side of the fistula, the tissues pared, and then sutured together, much as is done in the old perineal operation in the female. There was some delay in healing, due to the fact that the sutures were removed too early, but for the past two weeks no urine has passed through the perineal wound. The bladder, which formerly held about four ounces, now holds about twelve ounces, and urination is far less frequent.

DR. L. BOLTON BANGS complimented Dr. Guiteras on the good result obtained. He stated that his own experience in treating perineal fistulæ by simply paring the edges and bringing the tissues together had not been very encouraging.

The CHAIRMAN, DR. OTIS, referred to the after-treatment of these cases, which he regarded as even more important than the operation itself, no matter what particular operation is done. It is very necessary to prevent urine leakage, and the cystitis which usually exists also demands attention. The patient should be catheterized as often as is necessary, and the bladder washed out with boric-acid solution, or some other mild antiseptic. It is also well to instruct these patients to take as little fluid as possible, so as to diminish the quantity of urine.

A New Method of Bladder Drainage.—Demonstrated by DR. R. H. M. DAWBARN.

This method, the speaker said, is only new in one sense. The same idea has long been used by dentists in keeping the mouth dry during dental work, and, about two months ago, Dr. Keen, of Philadelphia, gave a description of it in the *Annals of Surgery*. Dr. Dawbarn said he has been in the habit of employing it after suprapubic cystotomy for the past three or four years, and found it very satisfactory. The method he employs is simpler than that described by Dr. Keen. It consists of an ordinary fountain syringe, the reservoir of which is filled with water and can be placed at any height; a screw clamp is attached to the rubber tube of the syringe, and reduces its caliber to such an extent that the water can only escape from the reservoir drop by drop. A turn is then made in the lower end of the tube, forming a circle, and between this and the screw clamp above a small slit is cut into the rubber tube. Into this slit the end of another, smaller, rubber tube is fastened, the opposite end of which is inserted into the bladder. In this manner perfect and continuous drainage of the bladder can be maintained. The principle is the same as that employed by plumbers in the ordinary water trap.

DR. EUGENE FULLER said the method described might be useful in some cases of bladder drainage, especially after the bleeding stage had passed. With severe cystitis and a free discharge of mucus or clots the tube would be very apt to get clogged. The method he usually prefers is to suture the suprapubic wound as soon as possible and depend chiefly on perineal drain-

age. Following this plan, his results have been better and the patients get well quicker.

Dr. Dawbarn replied that the objection mentioned by Dr. Fuller, namely, the possible clogging of the tube, applies to all methods of drainage in which a tube is employed. As to the question of closing the suprapubic wound immediately, he said that Dr. Fuller probably would not do this in a case of severe cystitis, such as commonly accompanies stone in the bladder. In other cases, closing the upper wound is a matter of opinion. In many of these cases a double cystotomy is unnecessary.

An Instrument for the Massage of the Prostate.—Exhibited by Dr. G. K. Swinburne.

The speaker exhibited an instrument which he devised for the purpose of massaging the prostate in cases of chronic prostatitis. It has a peculiar curve, made to imitate the curved finger. He has found it particularly serviceable in those cases in which the prostate is beyond the reach of the finger. Dr. Swinburne said that many of these cases of chronic prostatitis, which are often accompanied by a posterior urethritis of long standing, he formerly regarded as cases of seminal vesiculitis.

Dr. Fuller said that while this instrument might have its uses in certain cases, he preferred to employ the finger, by means of which he could detect the exact condition of the parts. In cases where the prostate is beyond the reach of the finger, this instrument would be very serviceable. In cases where the seminal vesicles are involved he thought very little benefit can be obtained by limiting the massage treatment to the prostate.

Dr. Bangs said that, without endeavoring to diminish the value of the original labors of Dr. Fuller in this field, he had arrived at the same conclusion as Dr. Swinburne. He had found that in many cases, both in young men and in old men with supposed senile hypertrophy of the prostate, much benefit might often be derived from massage of the prostate, irrespective of the seminal vesicles. In some instances the latter could not be reached at all from the rectum. He also agreed with Dr. Swinburne that many of these patients have a complicating chronic posterior urethritis, which demands attention. For the purpose of massaging the prostate, Dr. Bangs regarded the finger superior to any instrument; many conditions may be present which can only be appreciated by the finger.

Vesical Calculi removed by Suprapubic Cystotomy.—Dr. R. W. Taylor exhibited three specimens. The first was removed from a man twenty-four years old, who gave no venereal history. Four years ago he passed a rough calculus, about the size of a pea. The stone removed by Dr. Taylor weighed 1010 grains. It was composed of uric acid and oxalate of lime, and its surface presented little pigmented tuberosities, like nipples. The second stone shown was removed by suprapubic cystotomy from a boy fourteen years old, who for ten years had suffered from difficulty and pain on micturition. The stone weighed 256 grains; it was composed of uric acid covered with phosphates. The third specimen was removed from a man, fifty-six years old, who entered the hospital on October 25, 1895, in a very poor condition of health. His kidneys were diseased and he had a severe cystitis. Operative interference was postponed until December 17th, when a calculus weighing one hundred and eight grains was removed. Since then the man's vesical symptoms have greatly improved.

Dr. B. B. Gallaudet exhibited a stone which he had removed from the bladder of a boy aged seven years by suprapubic cystotomy. It weighed one ounce and externally was composed of phosphates; its internal structure had not been determined. The patient's symptoms extended back for a year and a half or two years. The speaker said he performed the operation without dilating the rectum or putting any fluid or air in the bladder; these measures he did not regard as necessary as a matter of routine. The suprapubic wound was left open and packed with gauze, the bladder was stitched to the muscular planes (not to the skin), and the surface allowed to granulate.

Dr. Bangs said it would add to the surgical interest of these cases to know why litholapaxy was not done instead of suprapubic cystotomy, at least in three of them.

Dr. Gallaudet replied that the stone felt hard, and it did not occur to him to resort to any other method in order to remove it.

Dr. Taylor said that in his first case the bladder was so much reduced in size that crushing the stone was out of the question. The second specimen was removed from a boy fourteen years old with a very small urethra. The third patient was in such poor condition that any interference with the neck of the bladder would undoubtedly have resulted in urinary poisoning.

Dr. Dawbarn said that in performing suprapubic cystotomy he is accustomed to introduce a sound into the bladder, the point of which serves as a guide in making his incision into the cavity. The patient's buttocks are elevated and the bladder distended either with water or air, pumping it in through a metal catheter, which also serves the purpose of a sound. He has given up the use of the rectal bag.

Morphology of the Seminal Vesicles.—Dr. G. S. Huntington gave a very interesting address on this subject. He stated that he chose this subject because, with one or two exceptions, the current descriptions of the anatomy of the seminal vesicles are more or less unsatisfactory. The speaker illustrated his remarks with numerous lantern slides, comparing the human seminal vesicles with those of other vertebrates of the mammalia class.

At the conclusion of his address the thanks of the section were extended to Dr. Huntington.

Book Reviews.

Die Geschichte der venerischen Krankheiten. Von J. K. Proksch. Zweite Theil. Bonn: P. Hanstein, 1895.

In our issue of September, 1895, we had the pleasure of noticing the first part of this very exhaustive history. Shortly after that the second part of the same history came into our hands. It is a much larger book than its companion volume, having eight hundred and ninety-two pages, against the other's four hundred and twenty-four pages. In the first part, the history of venereal diseases was brought down to modern times; the second part takes up the story and brings it down almost to date. Modern history is con-

sidered under five periods, namely, the age of Fernel, of Astruc, of John Hunter, of Ricord, and of the successors of the latter.

As we said in the notice of the first part, this study is one that is indispensable to every student of the subject. One most commendable feature of the book is that each part has its own index and separate paging. This greatly facilitates us in the use of the book.

Epithélioma Primitif de l'Urèthre. Par Melville Wassermann. G. Steinheil, Éditeur, Paris.

The author of this most interesting little work gives an extremely clear and concise study of what has been considered by most observers as either a very rare or even non-existent disease, the earlier writers either not mentioning it at all, or else regarding it as a part of a general cancerous affection of the genital organs, or perhaps as belonging almost exclusively to the female.

He has collected forty-four cases (twenty male and twenty-four female), besides three cases of cancer of Cowper's gland, the latter being considered on account of the intimate connection of the gland with the urethra, and the great possibility of confounding the two varieties, both clinically and anatomically, although the symptoms and situation are different.

Between the male and female the difference is only an anatomical one, the essential characters being the same in both sexes, and the author is right in considering them together.

Due credit has been given the German writers, who alone seem heretofore to have studied the subject at all thoroughly.

As far as possible, a full and minute history of each individual case up to date is given, together with results of operations, if performed, as also the result of any histological examination made, and no diagnosis is accepted as positive unless proven by histological examination. Macroscopically, epithelioma of the urethra varies according as to whether it is in the male or female; in the latter it is easier of inspection, and we often see it at the beginning of its development, where its favorite seat is at the meatus and the inferior surface of the urethro-vaginal wall. In man it is more hidden to the eye, localized in the interior of the tissues at a certain depth, and remains unperceived for a long time.

The section on histology is very thoroughly dealt with and discussed, and attention is called to the fact that so many cases have developed upon old gonorrhœal strictures. Perineal fistulæ are given as one of the most frequent complications, although only in the male, and are a great aid in diagnosis, especially with a histological examination of the surrounding granulations, but exploration of the urethra with a *bougie-à-boule* gives especially valuable information, and two important points are brought out: first, that the bougie is arrested by some obstruction at a variable depth, not, however, necessarily at the places of predilection chosen by gonorrhœal stricture, and, secondly, the beak of the instrument falls into a cavity immediately beyond the obstruction, caused by destruction of the urethral wall. The hæmorrhage produced by such an examination would awaken our suspicions, when examination with the endoscope would be indicated, but, unfortunately, this has only been used in two cases (those of Oberländer and Grünfeld).

The course of the disease is variable, generally rapid, but it may develop upon a benign tumor which has lasted many years.

The results of surgical interference are not very encouraging (but one case among both sexes having remained "cured" after a period of three years), the operations being either (*a*) resection of part of the urethra, (*b*) amputation of the penis, or (*c*) complete extirpation (accordingly as the parts are involved), with or without suprapubic cystotomy. Inguinal glands should be extirpated as radically as possible.

As palliative treatment: Suprapubic cystotomy, or, in the female, the establishment of a vesico-vaginal fistula. These are sound surgical rules, but discussion of them, as applied to the various cases, would lead us too far.

The importance of an early diagnosis can not be overestimated, and too much stress can not be laid upon the value of endoscopic and microscopic examinations where possible, but, unfortunately, many of the cases have not been seen early enough. Although Dr. Wassermann has dealt with a disease which is extremely rare, yet his work upon the subject has been most thorough, would well repay a reviewal, and is a valuable addition to surgical and genito-urinary literature. JOHN VAN DER POEL.

Selections.

Castration in Hypertrophy of the Prostate. ALBARRAN, Ninth French Surgical Congress (*Annales des maladies des organes génito-urinaires*, December, 1895).

To judge of the therapeutic value of castration, it is not best perhaps to simply take the general results of a large number of cases, and make up a percentage of deaths, improvements, and cures, but rather to study and analyze the results according to the case and to the stage of the disease.

Albarran considers the operation, first, as to its effects upon the volume of the gland, and secondly as to its effects upon the contractility of the bladder.

I. Effects upon the volume of the gland: *Experimentally*, upon the normal prostate, atrophy has been demonstrated in the dog, although we must be extremely careful before affirming an atrophy, as there is no constant relation between the weight of a dog and its prostate. Histological examination alone will prove it. *Clinically*, it has been demonstrated by many observations. In a majority of the cases, it is slow. In one of Albarran's cases it was not perceptible at the end of one month, but well marked three months later. A large part of the reduction in volume is due to a reduction in the quantity of blood in the part, the "decongestion," which can amount to one third of the volume of the hypertrophied gland. This "decongestion" is especially well shown in cases of retention of urine, by diminution in volume and consistence several hours after operation, or on the following day, and by an amelioration of the functional symptoms at the same time.

II. Effects upon the contractility of the bladder: Even in the healthy bladder retention causes a temporary loss of contractility.

With hypertrophy of the prostate castration acts upon the contractility

of the bladder, in diminishing the volume of the gland, which will help or even cure certain retentions. Perhaps it acts upon the bladder itself by diminishing its congestion, and also by empowering its inhibitory contractility.

Contraction acts upon the contractility differently according to the case:

1. *Prostatics with Dysuria without Retention.*—Here the vesical contractility being preserved, but the frequence of micturition being increased from congestion of prostate and bladder, castration almost always diminishes the number of micturitions, but, besides the "decongestion," we can not say how much is due to amelioration of the cystitis.

2. *Prostatics with Acute Retention.*—Castration seems to act especially by relieving congestion of bladder and prostate, but almost all cases of this class have been catheterized, and we can not say how much was due to the latter, as catheterization alone causes improvement, and often is all that is necessary.

3. *Prostatics with Incomplete Retention.*—The muscular coat of the bladder is weaker, and the importance of congestion is less. The benefits obtained are probably especially due to atrophy, which, in diminishing the volume of the prostate, renders easier the work of the bladder.

4. *Prostatics with Chronic Complete Retention.*—Here we have some extremely rapid improvements and some complete cures, which can only be understood by supposing either none or a very slight selerosis of the muscular coat of the bladder.

In general, the large percentage of deaths (twenty-two out of one hundred and thirty-five cases), is partly explained on the supposition that some of these would have died shortly any way. There are general contraindications in surgery to all operations of this gravity, and if ignored, naturally the mortality of this operation, which in the majority of cases is in men over sixty years of age (some over eighty), will be high. It is doubtful whether cases of dysuria without retention, or a case of acute retention, would require interference of this kind.

With chronic retentions, complete and incomplete, castration should be proposed when catheterization has not been sufficient to cure the case, and especially in cases of habitual difficult catheterization. We are more likely to have success when the bladder still possesses its power of contraction, even though weakened. JOHN VAN DER POEL.

The Treatment of Pyelitis with Irrigations of the Pelvis Renum per Vias Naturales. DR. L. CASPER (reprint from *Allgem. med. Centralzeitung*, 1895, No. 77).

Most of the readers of this Journal no doubt know that the author of this paper has invented and described a cystoscope through which we are able to catheterize the ureters. Although Nitze, the father of cystoscopy, in a rather animated discussion with Casper has claimed that he had constructed and used a similar "ureter cystoscope" for a long period, it is through the efforts of Casper that the new instrument was put on the market, and that the medical profession at large is enabled to examine the urine of each kidney separately by means of a catheter introduced into the respective ureter. The next step in using this method for diagnosis was to employ it likewise for therapeutic purposes, as the author did in two cases of pyelitis which he describes in this paper.

The first one, a man thirty-four years of age, was a case of pyelitis subacuta gonorrhoica, which was at first diagnosticated and treated as cystitis colli gonorrhoica. As there was very little improvement after the usual therapeutic measures, the bladder was drained with a catheter *à demeure* in the urethra, a procedure which relieved the unbearable tenesmus for the time when the catheter was left *in situ*. The failure of the local treatment, the general condition of the patient—who had lost twenty-five pounds in weight—the large amount of pus and albumin in the urine, the pain radiating into the region of the left kidney, made Casper suspect a pyelitis ascendens on the left side. On catheterization a "thick mass" was found to come from the left ureter, more of the appearance of pure pus than of urine. The catheter was left *in situ* for four days, and irrigations of the pelvis were made on the second, third, and fourth days, with fifteen cubic centimetres of a three-per-cent solution of boric acid, followed by the same amount of a one-per-cent solution of nitrate of silver, repeated after ten minutes. On the fourth day the strength of the silver solution was increased to two per cent.

As the improvement that followed this treatment did not meet the expectations of Casper, he suspected that there might be also a pyelitis of the right kidney. Therefore the right ureter was catheterized, and slightly cloudy urine was drawn. Ten cubic centimetres of a two-per-cent solution of nitrate of silver were injected into the right pelvis, and five cubic centimetres of the same solution were instilled into the ureter while the catheter was withdrawn. Marked improvement followed this treatment, which, however, could not be repeated on account of an epididymitis caused by the frequent use of the catheter. The patient nevertheless improved under internal treatment, and a cure was effected after a sojourn in Wildungen.

The second case, a man aged twenty-eight years, had been treated with irrigations of the bladder for two months without any effect. The urine remained cloudy, urination was frequent (every hour to an hour and a half) and painful, the pain radiating from the glans penis into the region of the left kidney.

The left ureter was catheterized and the diagnosis ureteritis et pyelitis gonorrhoica chronica was made. The bladder and pelvis were irrigated with nitrate of silver (1 to 1,000) at intervals of four days, the former twenty times, the pelvis only six times. Internally the waters of Wildungen and Fachingen were given in large quantities. A prompt recovery took place.

From these two cases the author concludes that the cure was due to the treatment of the pelvis and ureter, that the procedure proved to be perfectly harmless (epididymitis ?—G.) in his cases, and that the treatment is indicated in all cases of chronic gonorrhoic pyelitis and in those cases of acute pyelitis where the ordinary treatment is not followed by a marked improvement within a short time. GOLDENBERG.

Alterations in the Blood Occurring in the Course of Mercurial Treatment of Syphilis. WLADISLAW REISS (*Arch. f. Derm. u. Syph.*, vol. xxxii, fasc. 1 and 2).

The author treated more than one hundred cases of syphilis with subcutaneous injections of 0·01 gramme of sublimate *pro die*, gradually increasing the amount of sublimate up to 0·02 gramme. The average number of injec-

tions received during the course of treatment was from thirty to forty, always given at the same hour, and the blood taken for examination always at the same time three or four hours after injection. Only in severe secondary or tertiary cases were inunctions of three to four grammes of blue ointment employed.

The author draws the following conclusions :

1. The number of red blood-corpuscles diminishes even in the primary stage of syphilis.

From the beginning of the secondary eruption the decrease of the red blood-corpuscles becomes greater in proportion to the development of the eruption, and continues for a certain period even after the beginning of treatment.

2. The leucocytes remain unchanged during the primary stage, and only a relative leucocytosis is visible. From the beginning of the secondary eruption a constant increase of leucocytes takes place.

3. Of the white blood-corpuscles, only the lymphocytes increase in number.

4. A decrease of hæmoglobin can be demonstrated in the first week after the appearance of the primary induration. It is intensified also in proportion to the development of the secondary eruption.

5. During the mercurial treatment the red blood-corpuscles gradually increase, and after thorough treatment the number of the red blood-corpuscles is larger than before the appearance of the eruption.

6. The number of white blood-corpuscles, especially of the lymphocytes, diminishes from the beginning of mercurial treatment, reaching their normal amount at the end of the course of treatment.

7. The amount of hæmoglobin increases with the beginning of mercurial treatment, and reaches normal after a thorough but not prolonged course, as the prolongation of mercurial treatment often decreases the amount of hæmoglobin.

8. The relation between red and white blood-corpuscles is subjected to changes in all stages of syphilis, even during treatment.

9. Upon the blood plaques syphilis has no visible effect. LAPOWSKI.

On the Visceral Complications of Erythema Exudativum Multiforme. WILLIAM OSLER (*Amer. Journ. of the Med. Sciences*, December, 1895).

In order that there may be no misunderstanding as to his meaning in the title used in his paper, Prof. Osler defines exudative erythema as "a disease of unknown ætiology with polymorphic skin lesions—hyperæmia, œdema, and hæmorrhage—arthritis occasionally, and a variable number of visceral manifestations, of which the most important are gastro-intestinal crises, endocarditis, pericarditis, acute nephritis, and hæmorrhage from the mucous surfaces." A striking feature of the disease is the tendency to recurrence, attacks continuing month after month, even for many years. Sight should not be lost of the fact that the form of skin lesion varies in succeeding outbreaks, taking the shape of an angio-neurotic œdema in one, a multiform or nodose erythema in a second, a peliosis rheumatica in a third. Another important point to which attention is drawn is the occasional absence of cutaneous manifestations; the visceral complications are alone present, and to the eye the patient may present none of the features of erythema multiforme.

The author reports eleven cases of his own, remarking later on the singular absence in American and English text-books of reference to this symptom-group, the visceral complications being summarized as follows :

"In all, gastro-intestinal crises occurred—colic, usually with vomiting and diarrhœa; five had acute nephritis, which in two cases was followed by anasarca and death; hæmaturia was present in three cases; hæmorrhage from the bowels in three cases, from the stomach in two, from the lungs in two, from the nose in three cases ; one patient had spongy and bleeding gums ; two presented enlargements of the spleen; in one case there were recurring attacks of cough and bronchitis without fever; in one there was a heart murmur. Five of the cases had swelling about and pain in the joints. The skin lesions were polymorphic, ranging from simple purpura to extensive local œdema, and from urticaria of all grades to large infiltrating hæmorrhages of the skin and subcutaneous tissues. Of the cases reported, in only one was the attack single. In the others there were multiple outbreaks distributed over periods ranging from two months to eight years. Hæmorrhage was the most constant lesion. A remarkable circumstance, which was not seen mentioned in the literature, is the recurrence of severe attacks without cutaneous manifestations."

The literature is reviewed from Willan's first description in 1808 to 1893. Sixty-one cases (including forty-one tabulated by v. Dusch and Hoche and the author's eleven) have been so far reported. Among these there were thirteen deaths—21·3 per cent. *Gastro-intestinal crises*, Henoch's purpura so called, are much the most common of the visceral complications. The attack bears no relation to food, and may consist in colic of any grade, diarrhœa, and vomiting. *Nephritis* was present in fourteen instances, of which four died. In the mildest grade there is only a trace of albumin, with a few tube casts; in others, there are all the gravest symptoms of acute hæmorrhagic nephritis. In one case only, reported by Prentiss, of Washington, did the renal disease become chronic; gangrene and sloughing following cutaneous hæmorrhage were also marked features. *Hœmorrhage* from the mucous surfaces is next in importance, occurring in thirty-nine cases from the bowels, from the nose in three, from the lungs in two, the kidneys in three. In one case of Osler's the gums were spongy and bled profusely. None of the patients died from hæmorrhage directly. Of *cardiac complications*, endocarditis occurred twice, pericarditis three times. *Respiratory complications* are not common. Bronchitis appears most often, though pneumonia, when present, is usually of grave import. *Arthritis* was found in thirty-two of the collected cases, the periarticular being more commonly affected than the intra-articular tissue. A rare accident is peritonitis from perforation, a result of necrosis and ulceration analogous to that in the skin in the intestinal mucosa. One attack of erythema occurring in the course of a gonorrhœa is interesting in view of the fact that gonorrhœa is one of the infections in which true purpura occurs, and of which a fatal case has been recorded. J. C. J.

The Metastasis of Gonorrhœa in Internal Organs. E. LEYDEN (*Dermatol. Zeitschrift*, vol. iii, Part I, 1896).

Gonorrhœa of the internal genito-urinary organs had been recognized and accepted long before the discovery of the gonococcus; but the connection

between gonorrhœal disease and an affection of a remote organ is only a scientific achievement of latter years, due to the discovery of the gonococcus by Bordoni-Uffreduzzi in the joints of a patient afflicted with gonorrhœal rheumatism.

Subsequently Paltauf obtained pure cultures of the gonococcus from a gonorrhœal abscess of the metacarpus, and F. Neisser in gonorrhœal arthritis.

Cases of myelitis or meningitis occurring during or after a gonorrhœal attack have been long known, and have been explained by the reflex theory (Romberg, Stanley), or by Remak's hypothesis that superficial neuritis, occurring in gonorrhœa, is translated *per continuitatem* to the spine.

The autopsies did not reveal at that time any anatomical changes in the spinal cord. The author was the first to find anatomical changes in the spinal cord of a patient who died of urinary paraplegia, connected with a chronic cystitis of gonorrhœal origin—that discovery put an end to the reflex theory. Finally, Rayer's researches established the fact that urinary paraplegiæ are of gonorrhœal origin, and anatomically represent the features of myelitis and meningitis. At present it is not decided whether the metastasis is a product of gonococci alone or of mixed infection, as Barrié obtained from a liquid taken from the dura mater of the spinal cord of a patient who died of suppurative spinal myelitis of gonorrhœal origin, diplococci, not decolorized by Gram's method—probably staphylococci. Only future researches will solve the question. As to gonorrhœal endocarditis, the results are more encouraging.

Simultaneous occurrence of symptoms of heart disease during the course of an infectious malady has been known for years, and the connection between gonococci and endocarditis has been surmised as long ago as in 1862 by Traube and Leyden. But only in 1893 did Leyden demonstrate diplococci in the aortic and mitral valves of a patient who died of endocarditis ulcerosa acuta during a gonorrhœal attack. The diplococci had all the characteristic forms and properties of gonococci found in the urethra—namely, they were located in the cells, and were decolorized by Gram's method. It was only impossible to cultivate them on any known medium. But the latter deficiency confirms the diagnosis of gonococci, as a culture of staphylococci is very easily obtained, and until now gonococci have been cultivated only from fresh germs. The fact that the diplococci have been found in the cells shows that they are an essential factor of the disease, and not an accidental admixture.

LAPOWSKI.

The Local Changes resulting from Intramuscular Injections of Insoluble Mercurial Preparations. DR. MAX WOLTERS (*Arch. f. Derm. u. Syph.*, xxxii, 1 u. 2).

The author made an autopsy on the body of a female who, being affected *intra vitam* with syphilis, received sixty-two intramuscular injections of salicylate of mercury. Hard lumps were left in the glutei, perceptible up to the death of the patient, which occurred two years after the last injection. She died of phthisis pulmonum.

Macroscopically, the gluteus maximus presented a considerable number—probably corresponding to the number of injections—of spindle-shaped projections, raised above the muscular tissue. The gluteus maximus was united with the gluteus medius by these prolongations.

Microscopically, the septa of connective tissue were enlarged and showed abundant nuclei, the muscular fibers being diminished. In the middle of the focus the growth of the connective tissue was so great that the muscular fibers appeared surrounded by connective tissue; an increase of the muscle-nuclei—i. e., nuclei located under the sarcolemma—was also visible. A considerable number of *Mastzellen* was scattered around the fibers. Neither bacteria nor remains of mercury were present. There was an atrophy of the muscle, and a replacement of it by fatty tissue.

The injected mercury acted as a tremendous irritant upon the connective tissue, which responded by increased activity, by new formation of vessels, and by an enormous proliferation of connective tissue in the muscular septa. This explains the transformation of the solid glutei into flabby masses.

LAPOWSKI.

Comments on the Controversy as to the Nature of the Change of Cells in Molluscum Contagiosum. M. KUZNITZKY, with an answer by TOUTON (*Arch. f. Derm. und Syph.*, xxx, 1, 2, and xxx, 3).

Kuznitzky accepts the following statements as definite: (1) The contagiousness of the disease; (2) the fact that the disease is the product of epithelial hypertrophy and has no relation to the sebaceous glands; (3) the view that the proliferation of the epithelium commences especially if not exclusively in the upper layers of the rete and not in the mouths of the follicles or in the roots of the hair. The character of the epithelial change only is disputable; whether it is of degenerative nature, or represents the organized parasites of the disease, is not yet decided.

In order to form an opinion on the last point, the author examined microscopically sections of molluscum, hardened after the alcohol-celloidin method and stained with hæmatoxylin or with Unna's polychrome methylene blue. (Other methods also give good results.)

He noticed the following changes: "In the beginning an unstained, homogeneous, and light refractive substance is separated and, taking different forms, presses on the stained cell nucleus, causing it to assume various shapes, since its membrane does not give way at this time. The unstained, homogeneous, light refractive substance appears—independently of the changes in the nucleus—in the protoplasm of the cell, and increases both in the cell and nucleus.

"The membrane of the cell resists the pressure from within, but the membrane of the nucleus gives way, and the contents of the nucleus mix with the integral parts of the cell. The cells reach at this period the maximum of their growth. Henceforth the homogenous substance decreases, and minute particles of that substance arrange themselves like rows of pearls and, coalescing, form a network, dividing the protoplasm in a number of globular bodies with stained nuclei. Among those spherical bodies one, on account of its darker hue, is more noticeable and contains the remainder of the traceable chromatin of the nuclei. The chromatin gradually, with the decrease of the volume of the cell, takes the stain more readily and shows irregular sharp contours in those cells in which the disappearance of the unstained, homogeneous substance reaches its highest degree. These cells retain to the end their sharp outlines, the protoplasm gradually disappearing, its granulation growing less distinct, the appearance more homogeneous. In this stage, for

the first time, the netlike figures of granulating particles appear, irregularly shaped, ill defined, but stained more deeply than the protoplasm.

"It is hard to determine where the netlike figures lie, as they are visible on the same level with the figures containing chromatin in the middle of the cell."

The author comes to these conclusions :

1. The theory, that the changed cells contain coccidia, is untenable.

2. The so-called "molluscum bodies" are in genetic relation with the normal prickle cells.

This article was an answer to Touton's paper, published in the *Arch. f. Derm.*, in which he accepts the molluscum bodies as coccidia. To the foregoing Touton replied that until Kuznitzky shall have defined more exactly what he understands under the name of "homogeneous" degeneration, he—Touton—must retain his previous opinion. After Kuznitzky's definition of the term homogeneous degeneration, Touton remarks that the changes of the nuclei described by Kuznitzky are contractions, artificially produced.

LAPOWSKI.

Vesical and other Injections, Poisonings by.—BINZ (*Berliner klinische Wochenschrift*, No. 3, 1895) urges care in the injection of active drugs into the bladder, uterus, and other natural and artificial cavities. He cites several cases in support of his warning, of which the following are of special genito-urinary interest :

A physician, to rid himself of pin-worms, took a rectal injection of corrosive sublimate, 1 to 1,000, which was followed by a violent mercurial poisoning.

Coen and Levi tested the healthy vagina's ability to absorb potassium iodide, salicylic acid, salol, and antipyrin. They found that these drugs, or their constituents, can be found in the urine ; this absorption is intensified in pregnant and parturient women and in patients in febrile conditions.

[*Reviewer's Note.*—The article above excerpted recalls a paper On Cryptogenic Cystitis and Pyelitis, by Prof. Carl Posner, of Berlin, which the reviewer had the honor of presenting to the American Medical Association at its Baltimore meeting in May, 1895. In this paper Posner mentions a series of experiments showing that indigo-carmine injected into the rectum entirely disappeared from the intestinal tract within fifteen minutes and was found in the urine contained in the bladder and ureters, proving that cystic and vesical inflammations can and do take place by absorption of bacteria or toxic matter from the rectum *through the general circulation.*]

FERD. C. VALENTINE.

Are there Plasma Cells in the Normal Hematopoietic Organs of Man? Contribution to the Study of the Large Mononuclear Leucocytes. MENAHEM HODARA (*Annales de derm. et de syph.*, t. vi, No. 10, 1895).

After a short review of the work of Unna and v. Marschalko, on the plasma cells, repeating Unna's statement that he has never found them in the vessels of the skin, and his doubt that they are anything but the products of a pathological condition—in other words, transformed and hypertrophied connective-tissue cells—the author gives the result of his examination of fourteen spleens, lymphatic glands, and bone marrow. The specimens were taken from subjects of various ages, fœtus of three months to adult.

1. Of the fourteen organs, ten presented none of the true plasma cells of Unna, with the deeply stained protoplasm, form, and nucleus characteristic of these cells. In two, the plasma cells were found, but both the organs showed pathological changes, such as hypertrophy and extensive hæmorrhagic foci. In the remaining two, cells having the morphological characters of plasma cells, but distinguished from them by their excessively pale protoplasm, were found. In spite of their common morphological character, the author thinks (and Darier confirms him) that for this reason they are not quite identical with true plasma cells.

2. Hodara found in every instance cells with deeply staining nucleus and protoplasm, certainly belonging to the large mononuclear leucocytes which he calls *polyeidocytes* (because they are not always large, but may be medium-sized or even small), and which strangely resemble true plasma cells, but may be distinguished by certain nuclear characters. The nuclei of the polyeidocytes are irregular in shape, comparatively large, and stain almost always uniformly, while that of the true plasma cell is quite round, small, and shows the chromatin arranged in the form of large granules at its periphery. Protoplasmic peculiarities are apparently identical in the two, rarely taking the stain with any uniformity. The author believes these pseudo-plasma cells may be easily mistaken for the real bodies when the polyeidocytes have not been sufficiently deeply studied.

3. Hence he believes that the plasma cell of Unna is a purely pathological product (otherwise it would be found in these organs), and that there can be claimed for it no origin other than that from the connective-tissue cell (Unna), or from lymphocytes and their transition forms (v. Marschalko). J. C. J.

Primary Union after Suture of Vas Deferens. PARLAVECCHIO (*Gaz. degli ospedali*, 1895, No. 105, p. 1093).

Having accidentally torn across the vas deferens in operating for hernia, the author cut the torn ends of the vas obliquely, and united them by four very fine silk sutures of the order of Lembert sutures in the intestine. It seemed that the danger of stricture would be lessened by this method of union. Healing by primary intention occurred, and after two years and three months no thickening of the vas could be felt, no swelling or atrophy of testicle or epididymis could be made out, and sexual power remained perfect. (Translated in *Med.-Surg. Bulletin*, 1896, No. 16.)

Primary Malignant Tumors of the Clitoris. CHARLES GREENE CUMSTON (*Annals of Gyn. and Ped.*, 1896, No. 5, p. 268).

Carcinoma of the organ occurs after the menopause, and may have as a predisposing cause trauma, from labor or otherwise, syphilis, eczema of the vulva, vaginal discharges. The author thinks it occurs mainly in the lower ranks of society, resulting from conditions of poverty and vice. Its development is, as elsewhere, insidious ; heat, burning, pruritus, and a more or less fœtid discharge are among the early signs. A tumor, or ulceration of the nodular type of epithelioma, is found on examination. The inguinal glands are sometimes involved.

Sarcomata, simple, melanotic, or myxomatous, occur rarely. Their growth is rapid. Symptoms secondary to tumor of the clitoris are pain and difficulty

in walking, in coitus, in urination. Complete removal or dissection by knife and cautery, the author giving preference to the former, should be the treatment adopted.

Generalized, Exfoliating Dermatitis complicated by a Multiple Cutaneous Sarcomatosis. RUDOLPH KREFTING (*Annales de derm. et de syph.*, t. vi, No. 12, 1895).

This case belongs to the type of dermatitis exfoliativa primitiva of Wilson-Brocq. Beginning on the hands, the disease progressed until the entire body, trunk and extremities, was covered with an intense, thickened, œdematous, desquamating and burning redness. Thirst was consuming. There was no sweating. Later the face, neck, and ears became involved, the borders of the disease sharply defined. The nails became thick and opaque, some of them being lost. Œdema increased and desquamation took place in large plates. At the end of two or three months there developed on the forearm rounded, raised, violet tumors, pea-sized, which rapidly increased in number everywhere on the trunk and upper extremities. Besides these there were a number of points of telangiectasis. In a month the tumors ceased to increase in size, and shortly began to diminish rapidly. In six weeks nothing was left except pigmentation. Slight redness of the buttocks alone remained of the dermatitis. Hair and nails were lost. Two short relapses of dermatitis exfoliativa were seen, but no recrudescence of the sarcomatous nodules. Regeneration of the nails was rudimentary.

Histologically the tumors consisted chiefly of irregular bundles of fusiform cells of medium size united by normal connective tissue. Between the bundles were a number of round cells. Here and there, especially near the surface, were cavities communicating with each other and filled with blood. The passage between neoplasm and healthy tissue was insensible, round cells becoming more abundant. No melanotic or hæmatosic pigment was present. The diagnosis was multiple angiosarcoma, and to explain their involution the author has recourse to an hypothesis of sanguinolent degeneration, the blood cavities becoming larger, invading the whole tumor, and ending in coagulation, the neoplasm disappearing and leaving only the blood pigment. No treatment of the sarcomatosis was attempted. J. C. J.

Therapeutic Notes.

Argonine.—R. Meyer (*Zeitschr. f. Hygiene und Infectionskrankheiten*, 1895) has investigated the bactericidal action of this drug on various microbes, particularly the gonococcus. It is a mixture of neutral sodium cascinate with nitrate of silver. It is soluble in water, the solution becoming more opalescent with concentration. In the strength of 1 to 750 or 1 to 1,000 argonine possesses a disinfectant power in gonorrhœa equal or superior to argentamine (1-to-4,000 solution) or nitrate of silver (1-to-3,000 solution). It is non-irritant, and, while it does not penetrate the tissues deeply, it is not precipitated by albumin or chlorides.

Thyroid in Psoriasis and Vitiligo.—Mossé has obtained the disappearance of the cutaneous lesions in a case of psoriasis by thyroid feeding. It failed in a case of extensive lupus (*Annales de derm. et de syph.*, i, vi, No. 10, p. 892).

Nosophen.—Lassar (*Dermatol. Zeitschrift*, 1895, t. ii, p. 313) thinks nosophen may prove serviceable as a substitute for iodoform. It is nontoxic, almost odorless, and he finds it useful in infections, chancroid, genital herpes, balanitis, in burns made with the cautery, in erythematous lupus and angioma, and in nasal catarrh. Its desiccating action is excellent.

Herz (*Monats. f. prakt. Derm.*, 1895, t. xxi, p. 384) has used the preparation, especially in ulcers of the leg and soft chancre, in Unna's clinic. The secretion notably diminished and healthy granulations soon appeared, but in certain cases, where much inflammation of the borders was present, it caused severe pain. It may be used as a hæmostatic.

Iodine in Onychomycosis.—Sabouraud showed at a recent meeting of the Société de Dermatologie et Syphiligraphie a case of this disease in which the nails had been kept covered with a wet dressing, the solution consisting of iodine, 1: potassium iodide, 2; distilled water, 1 gramme; the dressing held in place by rubber finger stalls. After four months the nails showed a transverse line separating a peripheral diseased part and a central healthy one. The patient was on the road to recovery (*Annales de derm. et de syph.*, January, 1896).

Europhen.—Saalfield gives the preference to this medicament over iodoform on account of its odorless and nonirritant properties. It is used in powder or ointment (five to ten per cent) in intertrigo, pustular affections, pemphigus vulgaris, impetigo, and chancres, soft and hard (*Lewin's Festschrift*, Berlin, 1896).

Colchicum in Furunculosis and Acne.—Brocq states that colchicum is efficacious in boils occurring in gouty patients who are not albuminuric or diabetic in doses of three to four centigrammes daily. He cites the cure of an obstinate case. The local treatment was camphorated alcohol and Vidal's red plasters (*Brit. Jour. of Derm.*, from *Jour. de méd. et chir. prat.*, February 19, 1895). The same drug is useful in acne of the gouty. J. C. J.

JOURNAL OF
CUTANEOUS AND GENITO-URINARY
DISEASES.

VOL. XIV. JUNE, 1896. No. 6.

Original Communications.

KERATOSIS FOLLICULARIS (PSOROSPERMOSE FOLLICULAIRE VÉGÉTANTE, DARIER), APROPOS OF A NEW CASE.

BY JOHN T. BOWEN, M. D.,
Boston,
Physician for Diseases of the Skin, Massachusetts General Hospital.

SINCE this interesting affection of the skin was first described almost simultaneously by Darier and White, an occasional instance has from time to time appeared in the literature, so that we are now in possession of the clinical history of about twenty cases, contributed by French, German, Norwegian, and American observers. It has been no surprise to find also that a considerable number of cases previously described under other headings were examples, in all probability, of this same dermatosis, although convincing histological proof is wanting. The publication of twenty cases within a period of seven years proves that the disease, although rare, occurs more frequently than some other affections, whose clinical features and pathological appearances have been for a long period described and studied. The interesting observation of Darier, that peculiar cell forms that resemble coccidiæ are present in the cutaneous lesions, and his able exposition of the parasitic theory, have directed general attention to this subject on the part of those interested in skin affections, so that a larger number of cases have been recognized as examples of this affection than is usually the case when a group of symptoms is first accurately studied.

It was my fortune to observe and study at various times the two cases described by Dr. White, and to make an histological examination of numerous lesions and products of secretion and degeneration in

both. At the time that the first case was published (JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, June, 1889), we had no knowledge of Darier's work, which had been communicated to the Société de Biologie in March of that same year, but which first appeared in the *Annales de dermatologie et de syphiligraphie* of July. In this article Darier refers to White's case as probably identical in nature with his own, although the coccidia-like bodies had not attracted especial attention. An examination of a fresh and more abundant supply of material from this case, in the light of Darier's communication, proved that the peculiar cell forms existed in sufficient numbers, and that the disease was undoubtedly the same as that described by Darier. The affection had been called by White keratosis (ichthyosis) follicularis, as both the macroscopical and microscopical appearances suggested as the essential feature of the process a hyperkeratosis of the mouths of the hair and sebaceous follicles.

Soon after, a second case was published by White (JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, January, 1890), which afforded new material for the study of this interesting question, and my views with regard to the parasitic nature of the bodies in question were included in a report embodied in that article. Since then the subject has been of constant interest to me, and I have followed the series of reported cases with eagerness. In August, 1895, a fresh instance of the disease came into my hands, and, although the number of observations is rapidly reaching a point where a detailed description of single cases may appear unnecessary, I take the liberty, inasmuch as this is but the fourth case observed in America, of recording it in this place.

Case.—The patient was a woman twenty-nine years of age, living in a small city near Boston. Her father and mother were French Canadians, although she herself was born in the United States. No facts of importance in connection with the case could be obtained from her family history. She had no knowledge of the occurrence of any skin disease in any member of her family. One sister had died of phthisis two years previously. Two half-brothers and a half-sister were living and healthy. She had had an attack of diphtheria, and some "uterine troubles," but had been otherwise well, with the exception of the skin affection. She began to menstruate at the age of sixteen, and at this time, according to her own account, the skin of the face first became affected with the present trouble. Later, it spread downward gradually, but there had been no lesions upon the scalp until quite recently. There has been considerable itching, and she complains of a poor appetite and some debility.

The patient, when seen, presented the appearance of a fairly well nourished woman, of a dark, swarthy complexion. The face had an aspect quite characteristic of "Darier's dermatosis" to one who had seen and studied the affection. It was covered with lesions that did not vary much in color from that of the normal skin, although there was a distinct darkening of the skin as a whole, which looked coarse, furrowed, and greasy.

On closer inspection it was seen that the individual lesions consisted of small, greasy-looking papules. They were, on an average, of about the size of a pin's head, although both larger and smaller examples were present. When closely examined it was found that the center of each papule contained a fatty-looking mass or plug. In some, the tip of the lesion showed a minute pustule instead of the greasy plug.

These lesions were apparent over the whole face. In certain regions, however, they were larger and more prominent. These regions were the forehead between the eyebrows, the cheeks near the alæ of the nose, and the temples near the line of the hair. In these situations, elevated areas had been formed by confluence of the individual nodules. These areas gave to the finger the sensation of a nutmeg grater. The surface of these elevated areas was uneven. Scattered over it were smaller or larger crateriform openings, filled with firm concretions. Large and somewhat confluent lesions were also present in front of the ears.

The ears were prominently affected. The external auditory canal was filled with lesions, showing a central orifice which contained a firm concretion. Some of these lesions had become confluent. The skin immediately behind the ears was the seat of very prominent, almost hemispherical, lesions, much larger and more rounded than those that have been described. Some of them exhibited no sign of a central opening; in others, a firm concretion occupied the center. These lesions were more or less confluent, so that the whole space behind the ear presented an irregular, papillomatous, fissured appearance.

The hair of the head had been cropped pretty closely, and the patient wore a wig. The hairs were dark, coarse, and vigorous. The scalp was covered with a thick mass of greasy concretions, closely aggregated, which, when removed, were found to dip down into shallow, crateriform depressions, surrounded by a slightly elevated rim. There were also numerous small pustules and excoriations.

Upon the trunk, the parts especially affected were the sternal, interscapular, and sacral regions, and the median line of the abdomen from umbilicus to pubes. Here the lesions were numerous and closely

aggregated. They were dark and greasy-looking, and less elevated than those on the face. Some of them bore a strong resemblance to keratosis pilaris.

The labia majora were the seat of prominent lesions, some of them the size of a large pea. By confluence of the individual lesions the labia had become much thickened, and precisely the same irregular papillomatous appearance was produced as has been described as occurring in the spâee behind the ears.

There were but a few scattered lesions upon the arms and legs, of small size. The hands and feet were perfectly free.

The finger nails were easily broken off, but were not otherwise deformed. The nails of the toes were normal.

Close inspection showed that the greater part of these lesions were grouped about the follicular orifices—in other words, that the affection was essentially a follicular one, at least at its inception. All the smaller, evidently primary lesions were seated about the follicles. In some places, however, as in the space behind the ears and on the labia majora, where large lesions had by their confluence formed fungous-looking, irregular, elevated areas, it was evident that the process had invaded the interfollicular structures to a considerable extent.

Under the influence of an ointment of sulphur and salicylic acid, together with daily washing, the scalp, as was to be expected, became much clearer, the pustular lesions and much of the concretion having been removed. The individual small papular elevations were thus brought out more prominently. The hypertrophied lesions behind the ear were also considerably diminished in size, and a marked improvement was noted everywhere except upon the body, to which it is probable the patient gave much less attention than to the exposed portions.

With regard to the histology of this case several lesions were excised and examined microscopically. I shall later consider the histological appearances of the three cases I have studied as a whole, and it need only be said here that this case corresponded perfectly with the others in its general pathological features, and in the presence of the cells that resemble coccidiæ. It will be noted that this case represented a lower grade of development than the first case reported by White and examined microscopically by me. In my case the process had not progressed to the formation of distinct horns, and the amount of epithelial proliferation at the edges of the nodules was far less, so that the papillomatous, tumorlike masses were only seen in the spaces behind the ear and on the labia. In grade of development it corresponded closely with the second of White's cases.

Before discussing the pathology of the disease, it may be of interest to examine the clinical characteristics, as shown by the twenty cases that have been reported. These are from the following sources: Darier-Thibault (two cases),* White (two cases),† Boeck (five cases),‡ Buzzi and Miethke,# Lustgarten,‖ Schwimmer,^ De Amicis,◊ Schweninger and Buzzi,‡ Pawloff‡ (two cases), Fabry,‡ Mourek,** Jarisch,†† Bowen. The cases reported by Krösing, Manssuroff, and Zeleneff I have not considered. Krösing's case varies so essentially from the type of this disease that it should be placed aside for further study. Of Manssuroff and Zeleneff's cases I could find no sufficiently accurate description. Jarisch's differs more than any of the others from what we have now learned to be the clinical characteristics of this disease, but it is included on account of the histological appearances.

The age at which this affection begins seems to vary somewhat, so far as can be judged from the reported cases. It is probable, however, that it begins early in life, as in eleven out of the twenty cases the subjects testified that they were affected by or before the sixteenth year. In several it dated from early infancy. In all five of Boeck's cases it began between the eighth and the sixteenth year. It is extremely probable also that the testimony of the patients on this point is sometimes inaccurate, as an affection that is usually unaccompanied by subjective symptoms, and in which the primary lesions are insignificant, might very well excite little attention until fully developed. In some of the cases also there existed a motive which might induce the patient to declare the affection to be of later date than was true.

Of the twenty cases collected thirteen were males and seven females.

The portion of the body that was first affected is not mentioned in all the cases. In a considerable number, however, it was first noticed upon the head and face, extending afterward to the trunk and extremities.

It is to be noted that the affection belongs to the most obstinate of known dermatoses, as regards treatment. In most of the cases, espe-

* *Thèse de Paris*, 1889. *Annales de derm. et de syph.*, July, 1889.

† Journal of Cut. and Gen.-Urin. Dis., June, 1889, and January, 1890.

‡ *Archiv f. Derm. und Syph.*, 1891. Second International Congress of Derm. and Syph., Vienna, 1892.

Monatsheft. f. prak. Derm., January, 1891.

‖ Journal of Cut. and Gen.-Urin. Dis., 1891.

^ *Archiv f. Derm. und Syph.*, 1892.

◊ Vienna Congress, 1892.

‡ *Internation. Atlas seltener Hautkrankheiten*, 1892, ii.

‡ *Archiv f. Derm. und Syph.*, 1893.

‡ *Ibid.*, 1894.

** *Ibid.*, 1894.

†† *Ibid.*, 1895.

cially in those where no care had been taken of the skin, a marked improvement has been effected. This is due to the removal of the semicornified and sebaceous masses in great degree, which in some instances, as in the first case reported by White, are intolerably offensive to the smell. No one, however, has been able to record a cure, as the condition returns rapidly when the treatment is intermitted. In this respect the disorder bears a closer resemblance to the anomalies of development, as ichthyosis, for example, than to the class of parasitic affections.

A point upon which there has been much diversity of opinion is whether the lesions are essentially follicular or not. Indeed, it is difficult to understand why there should be such a lack of unanimity in the observations in this respect. Darier, as is well known, proposed the name *psorospermose folliculaire végétante* for the affection, declaring, on the strength of the two cases studied by him, that the process was one affecting the hair and sebaceous follicles especially, although foci of disease were often found apart from these structures. The primary lesion is defined by Thibault, whom Darier quotes, as "*une petite papule surmontée d'une croûte d'un brun noirâtre ou grisâtre.*" White, whose first case was published before Darier's article had appeared, named the disease keratosis follicularis, and stated that at the beginning of the process we have lesions in no way to be distinguished from those of simple keratosis (lichen) pilaris. Lustgarten, an accomplished histologist, also concurred in the view that the lesions were essentially follicular. On the other hand, Boeck, in his admirable article based upon five cases, declares that he is unable to determine that the lesions are in great part confined to the follicles, although he admits that clinically as well as microscopically such an association is sometimes seen. Most of the remaining writers who have published single cases concur in this view.

In the face, therefore, of so much difference of opinion among experienced observers, it is difficult to speak categorically. For our own part we must adhere to our original position, which was taken at the time that we made the histological examination of White's first case, and before the studies of Darier had come to our notice, viz., that the process is primarily and essentially a keratosis of the mouths of the follicles. In the three cases seen in Boston, and repeatedly examined by both Dr. White and myself, no question existed in our minds that the follicles were primarily affected. This could be verified in every instance by the use of the hand lens. Through the courtesy of Dr. Lustgarten I had an opportunity of seeing and examining the case reported by him, and here too the follicular situation was evident to the naked eye. In all these cases the process had extended outside of

the follicles also, as was seen especially in the confluent lesions behind the ears and in the groin.

Naturally, in the course of my studies of the two cases of White's and of the one above reported, I have made an histological examination of a great many different lesions from the three cases. In no instance where the small primary greasy papule was excised have I failed to find the process situated about a hair or sebaceous follicle. It is very difficult to distinguish the smallest of these lesions from papules of keratosis (lichen) pilaris histologically, although a careful search will usually reveal traces of the perverted process of cornification which characterizes the disease. In larger lesions, especially the confluent masses from the groin and behind the ear, where there is a marked proliferation of the epithelium, the follicular origin is by no means always apparent. So far as the cases that I have examined are concerned, I must record myself emphatically on the side of Darier and Lustgarten, that the process is one affecting primarily and chiefly the mouths of the follicles, although it unquestionably appears also in their vicinity. It seems not improbable, from the varying testimony of those who have reported cases, that the disease may affect the follicles to a greater or less extent in different instances. Otherwise it is difficult to account for the diversity of opinion on this point.

With regard to the pathology of the disease, I insisted in 1889 that the lesions were caused by a hyperkeratosis that affected chiefly the sebaceous and hair follicles. This process does not extend far downward into the follicle, but is principally confined to the neck. The peculiar cell forms that have been described by Darier as parasites belonging to the coccidiæ were abundantly present in the three cases I have examined. At the time that I made the examination of White's first case Darier's work had not been published in the *Annales*, and these bodies did not attract especial attention, the amount of material examined being small. In the light of Darier's admirable and exhaustive work, they were readily found in a fresh and more abundant supply of material that was obtained from the first case, which was still under Dr. White's observation, and also in the second case reported by him. In a report that was published in connection with the latter case * I stated that I had been able to find them, but expressed my skepticism as to their parasitic nature, basing my doubts on the presence of eleidin and keratohyalin in their interior, and on the fact that their intracellular position could not be verified. It was also stated that in various other anomalies of cornification such bodies

* Journal of Cutaneous and Genito-Urinary Diseases, 1890.

are occasionally seen, although never, so far as my experience extends, in such large numbers as in the disease we are dealing with. This has since been confirmed by Unna and others.

With regard to the presence of keratohyalin in these cells, my observations have been confirmed by Buzzi and Miethke, Boeck, and by most of the writers who have published cases. This circumstance affords perhaps the strongest argument against their parasitic nature, as such an association does not occur in the case of any of the known coccidiæ.

The question whether Darier's "*corps ronds*" are inclosed in epithelial cells, as was claimed by him, is one that is not easily decided by an unprejudiced observer, studying for the first time the histology of this disease. At one period of my studies I was inclined to agree with Darier on this point, although I had previously expressed an opposite opinion. Since then repeated examinations of the horny material from these three cases have failed to convince me that the round bodies in question are contained in cells. Darier's conclusions on this point are drawn chiefly from the appearances seen in preparations made by softening the horny masses with dilute ammonia or potash and staining with hæmatoxylon. In such preparations we occasionally meet with appearances very similar to those depicted in Plate IV, Fig. 3, of Darier (*Annales de derm. et de syph.*, 1889). The portion designated by *a*, which might be taken as the nucleus of the host cell pushed to one side by the parasite, is often, it seems to me, a part of the cell that has undergone an irregular cornification, and for this reason is differently affected by the staining agents from the rest of the cell. Certainly this explanation is a satisfactory one for many of the appearances seen by me in the so-called "squash" preparations. I have found it in these cases impossible to detect a distinct line of boundary between this supposed nucleus and the inclosed cell, and I am therefore inclined to regard the former as a part of the cell that has taken on a deeper stain than the remainder.

It seems to me that it is pretty well proved that the essential feature of the process is an irregular keratinization of the epidermal cells, a parakeratosis, as well as a hyperkeratosis, the formation of horny cells being effected in an irregular manner. Thus the "*corps ronds*" of Darier are epidermal cells that are enlarged and swollen, made up of a nucleus, with usually a clear or hyaline protoplasm around it (the kern-ring of Peterson),* and outside of this a zone containing granules of keratohyalin. Around and outside of this keratohyalin

* *Centralblatt für Bakteriologie u. Parasitenlehre*, October 16, 1893.

zone is the membrane so often referred to, that in some instances possesses a double contour (the mantel-ring of Peterson). This outer membrane is evidently an early cornified or hyaline structure, which is homogeneous and glistening and sharply bounded from the zone of keratohyalin. The keratohyalin zone gradually disappears in the upper more completely cornified layers, but this transformation is often accomplished in an irregular manner, so that at one portion of the zone a clump of keratohyalin which has partially lost its granular character may remain after the rest of the zone has become almost transparent. It is these clumps of partially transformed keratohyalin that produce the appearances in the "squash" preparations that at first sight impress one as the remains of nuclei. In sections no appearances are met with that simulate the nuclei of host cells.

The hyaline degenerated outer ring or membrane frequently becomes contracted or disappears in the upper layers of the rete and in the horny layers. In this way cell forms are often seen composed of nucleus surrounded by a ring of keratohyalin or partially cornified protoplasm; while, instead of the outer glistening double membrane, an empty space is observed. In other instances, the hyaline membrane is well seen in cells that are situated in the upper horny layers.

Another anomaly of cornification is found in these lesions. Many of the cells at the bottom of the follicle plugs become cornified without passing through the keratohyalin stage. Darier called attention at the outset to the frequent absence of the stratum granulosum at this point. These cell forms are rounded, sometimes polygonal, shrunken bodies, homogeneous, and with a feebly differentiated nucleus. These are the bodies that are seen in preparations obtained by macerating the horny plug, and to which Darier has given the name of "grains." It may be that some of the latter are formed from the "*corps ronds*," as it is certain, as Buzzi and Miethke have shown, that in some instances pretty direct transitional forms may be seen between the large round cells with hyaline glistening outer zone, and the compressed, homogeneous "grains." But the larger portion of the "grains" found in the horny plug, I think with Peterson and Unna, are epithelial cells that have become cornified without passing through the keratohyalin stage, and such as are seen loosely clustered, and not bound together, in the lowest rete layers. In the cases where a firm horn is produced, as occurred in the first case of White's, the horny plug is made up at its outer part of bands of horny fibers, running vertically and obliquely and without trace of the "grains." The outer portion of these horns, which were apparently more developed than in any other case yet

published, differed therefore in no respect histologically from the ordinary cutaneous horn.

Boeck first called attention to the presence of fissures or lacunæ in the lower layers of the rete. Buzzi and Micthke believe that these lacunæ are the result of an exudative process and are analogous to bullæ, since threads of fibrin and lymphoid cells have been found in them. I do not share this view, but believe with Boeck that they are caused by fracture occurring between the soft, pliable cells of the lowest rete and the hard, precociously cornified cells immediately above. This view is supported by the fact that similar fractures may be seen in other forms of hyperkeratosis, and that the appearances are not constant in this disease.

In the epidermis and corium at the borders of the lesions there is usually an abundant deposit of pigment. The amount of cellular infiltration in the corium is very small, and there can be no question that the affection is primarily and essentially a disease of the epidermis. The proliferation of the rete into the corium, which often produces tumorlike masses in the groin and behind the ears, has been recognized by all observers, and is undoubtedly secondary to the keratosis. In the primary, follicular lesion, which is still very small, this epithelial proliferation is not seen. No instance has yet been recorded where this epithelial activity took on a malignant character; but it would not be strange if such were exceptionally the case, in view of the fact that in other examples of keratosis such a change is sometimes observed.

It is not out of place to call attention, in conclusion, to the fact that at the time White's first case was published in 1889, and before Darier's interesting article had appeared in the *Annales*, the affection was regarded and described as a keratosis affecting primarily the follicles. With regard to this, his first case, that had reached a far higher grade of development than most of the cases since reported, White * says: "It is easy to trace the intimate connection between the various lesions by their progressive development from the minute primary papule to the largest masses of hornlike concretion. At the beginning of the process we have lesions in no way to be distinguished from those of simple keratosis (lichen) pilaris, while the other extreme is characterized by formations resembling well-marked ichthyosis cornea. The disease is, then, evidently in all its phases a keratosis, or primarily a hypertrophy, or modified cornification of the epithelial layers. It is also evident that its starting point is in or about the follicular open-

* JOURNAL OF CUT. AND GEN.-URIN. DIS., June, 1889.

ings." This view was supported by the microscopical examination that I made at the time, which proved to me conclusively that we had to do with a keratosis of the neck of the follicles.

When White's second case * was published, I expressed, as has been said, in a report incorporated in that paper, my skepticism as to the parasitic nature of the cell forms described by Darier, pointed out that the presence of keratohyalin and eleidin in their interior was inconsistent with the view that they were coccidiæ, and again insisted upon the anomalies of cornification that characterized the process.

This repeated reference to the years 1889 and 1890 has its justification in the fact that the later writers, with the exception of Boeck and Buzzi and Miethke, have approached the subject solely from the standpoint of Darier's article, and, while ignoring the work embodied in the reports of White's two cases, have finally arrived at conclusions that do not differ from the latter's as to the essential nature of the process.

The adjective follicularis may not seem appropriate to those observers who have failed to recognize the follicles as the chief and primary seat of the morbid process. As has been said, our own observations point to these structures as the parts chiefly and primarily involved, although we freely admit, with Darier and Lustgarten, that the process is not confined wholly to them, but is found also in their neighborhood.

Credit is due to M. Darier, who has done so much, by his description of the "*corps ronds*" and "*grains*," toward the general recognition of this interesting dermatosis. The brilliant and attractive theory that these cells represent parasites of the order sporozoa has not stood the test of time. With the abandonment of this theory and of the assumption that a great part of the concretions is made up of these parasites, we can no longer doubt that the view taken by White in 1889, from the clinical appearances, and confirmed by microscopical studies made by me, is essentially the correct one; viz., that "the disease is evidently in all its phases a keratosis or modified cornification of the epithelial layers." Both clinically and histologically it appears to resemble the anomalies of development, as exemplified by ichthyosis, more closely than any other group.

* Journal of Cut. and Gen.-Urin. Dis., January, 1890.

DYSTROPHIA UNGUIUM ET PILORUM HEREDITARIA.

BY CHARLES J. WHITE, M. D.,

Boston,

Assistant Physician for Diseases of the Skin in the Massachusetts General Hospital.

IN the month of December, 1895, William R. came to the out-patient clinic for diseases of the skin at the Massachusetts General Hospital. The peculiar lesions of the patient embarrassed us all for a diagnosis, and we were aided in no way by the replies to the questions put to him. That same evening, while reading the *Annales de dermatologie et de syphiligraphie* for August-September, 1895, I happened upon an article written by MM. C. Nicolle and A. Halipré, of Rouen, entitled *Maladie familiale caracterisée par des altérations des cheveux et des ongles.* The report in the French journal told of a patient suffering from congenital abnormities of the hair and of the nails, practically identical with those of our patient. Similar lesions, moreover, had been found to exist to a surprising extent in the family of the French individual—in fact, thirty-six people in six generations had been thus peculiarly affected. The paper by the French observers was extremely interesting, and I advise all who are to read this report to turn first to their article, if, perchance, they have not already done so.

MM. Nicolle and Halipré spoke of their cases as unique in dermatological literature, and for this reason, if for no other, I desire to report the Boston case and add it to those already published.

The subject of this paper is a native of Massachusetts. The family history is quite remarkable. On the father's side nothing worthy of report could be elicited, but the maternal branch of the house proved to be of great interest. This family came originally from France, and at some uncertain date settled in Canada The patient's great-grandfather had but very little hair, and the nails of his fingers and toes were somewhat faulty in development. A break then occurred in the chain, and this ancestor's children escaped the family inheritance, but unfortunately the peculiar condition appeared again in the third generation, and among eight children (six sons and two daughters) one daughter and two sons were affected. These are the mother and two uncles of my patient. The mother never had but very little hair. Her finger nails were for years thickened and abnormal, until finally they were wrenched away by some quickly revolving machinery. The hair of the two uncles is normal, as far as I could ascertain, but their nails are "bad"—to quote the words of the patient.

Finally, we come to the fourth or present generation. One of the uncles married, and has a boy of nine years and a little girl of four. The latter was born without hair or nails, and even now these two structures are entirely absent. The patient himself has one sister, two step-brothers, and one step-sister. These latter are without interest to us, but the patient's own sister presents a peculiar, thick, downy head of hair, quite different from a normal one—especially as the individual hairs are very blond and seldom exceed the fraction of an inch in length. Her hair has always been as it exists to-day.

All these data were gleaned after much questioning, and I can not vouch for their accuracy. Of the patient himself I can give a more detailed description, as I have seen him personally. He is nineteen years of age, quite blond, about five feet nine inches in height, well nourished in body and sound in mind. By occupation he is a man-of-all-work in the country, and has never known a day's illness, save for a temporary indisposition due to an accident, of which I shall speak later. All signs of previous constitutional disturbances are wanting; and I examined him carefully in the search for the stigmata of an inherited or an acquired syphilis, or an infantile tuberculosis cutis in any of its possible forms. In fact, the only cutaneous abnormity to be found anywhere upon his body (of course excepting the condition of the nails and the hair) is present upon his thighs, where the so-called cutis marmorata is very conspicuous.

The hairs of the head present many features of interest. The whole scalp is covered with a sufficiently abundant uniform growth of very pale, short, downy hairs, which are in no case broken at their ends, and which are visible only to a close observer. In fact, at a distance one would say that the man had but very little hair save on the top of his head. On the vertex the hairs have a maximum length of two inches, but still preserve many of the characteristics of their shorter neighbors—I mean the lack of pigment, the softness, the delicacy, and the pointed tip. At birth the patient had but very little hair; since then the quantity has very gradually increased, he thinks. Nevertheless, the hairs seem very insecurely rooted, and at present can be pulled out with ease in comparatively large masses without breaking. The scalp appears normal and healthy. There is no appreciable seborrhœa, and no scales or atrophies or cicatrices are present. Such is the condition of the man's scalp (Fig. 1), and we see that none of the more common forms of alopecia are to be thought of in this case.

The eyelashes and eyebrows exhibit no striking deviation from what is seen in many people. The eyelashes of the lower lids are somewhat sparse, and there is a slight thinning of hair as the external

borders of the eyebrows are approached—such as one observes frequently in syphilis, or meets with at times in association with keratosis pilaris of the arms. The hairs of the upper lip are decidedly of the lanugo type, while those which should be on the cheeks and chin are markedly absent. In the axillæ all hairy growth is lacking, and over the pubis a few spears of hair only are visible. Curiously enough,

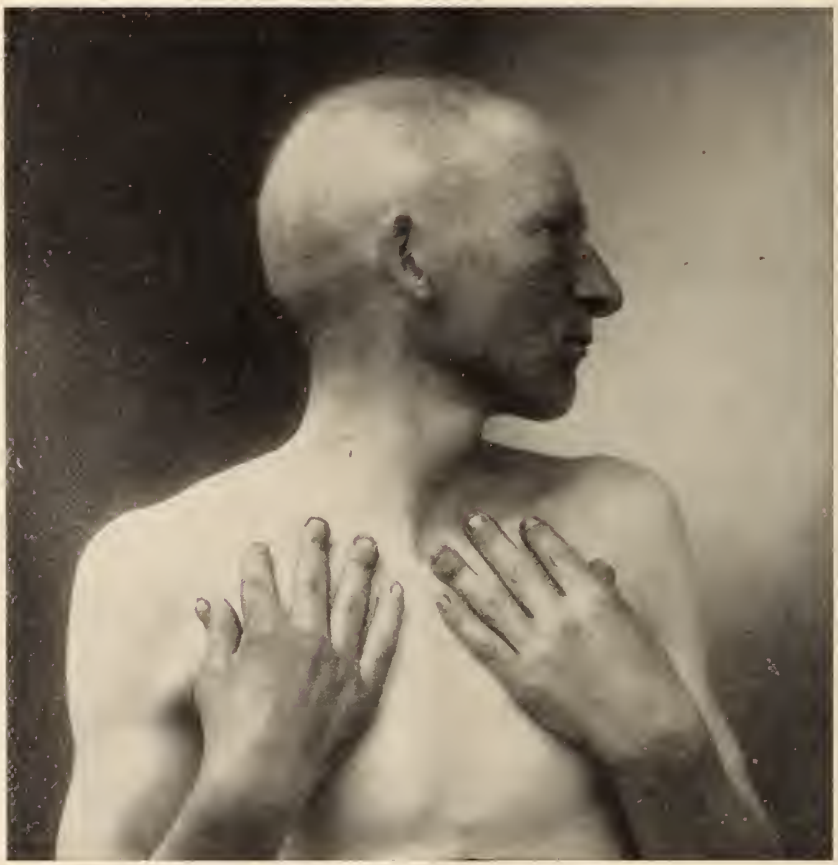


FIG. 1.

these few hairs are pigmented, comparatively long, but exhibit no tendency to curl as would be expected at the patient's age. The pubic hairs are, in truth, those of a boy of fourteen. Any signs of an adult hairy growth upon the trunk or the extremities of the patient are not discernible.

Finally, in the description of the disease we come to the nails. Up

to the age of nine years they were quite normal, but at this date two of the fingers were run over by a light wagon, and from that time the nails, one and all, of the fingers and of the toes have undergone periods of ulceration and other changes to be presently described. Interims of comparative health have succeeded periods of disease, so that a constantly changing condition has existed since the outbreak of the first symptoms following the carriage accident. The healing process has always been a very tedious one, and to-day the nails are in a wretched state, as will be seen in the accompanying photographs (Fig. 2).



Fig. 2.

The condition appears to me essentially an inflammation of the bed of the nails, and in one finger only is there any paronychia. The nails of all the ten fingers are broken off at varying distances from the matrix, and in addition are greatly thickened—in some instances to a full quarter of an inch or more—and their uneven ends are stained almost to blackness. The vertical striation is greatly exaggerated. The nails of all the fingers seem firmly implanted, and show no tendency to drop off entirely. The bed of the nails exhibits even greater signs of disease. Here one notes an extremely uneven surface of hypertrophic and ulcerating tissue in which little craters appear filled with

a sero-purulent matter. On firm pressure there oozes, apparently from beneath the broken remnants of the nails, a brown, ichorous fluid. The odor given forth from the finger tips is peculiarly potent and disagreeable—a characteristic manifested in the French case. The toes exhibit similar lesions, only to a much less extent. At present there is no active ulceration, but some of the nails are very dark in color, while others are quite normal.

On the 26th of February several cultures were made. Fluid from the beds of the nails was sown on blood serum and on agar-agar, and the roots of the hair were planted on Sabouraud's ringworm medium (agar-agar, 1·30 gramme; peptone, 0·50 gramme; maltose, 3·80 grammes; water, 100 c.c.). I regret extremely that I could procure no material for pathological sections, but such a step seemed impracticable. The results of these inoculations were as follows:

At the end of twenty-four hours the tubes were removed from the incubator, where they had been placed at a temperature of 37° centigrade. The appearances of the two colonies developed on the agar-agar and on the blood serum were practically identical and showed these distinctions: one, a thin, diffuse, rather translucent, grayish growth; and the other, little pin-points of a milky-white color.

After allowing the colonies to develop at the room temperature for a space of two weeks, the following changes had occurred: On agar-agar the translucent colonies had not thriven well. They had extended somewhat over the surface of the medium, but were still very thin and translucent. The little pin-point colonies, on the other hand, had grown upward surprisingly, and now appeared round and dome-shaped, at least one millimetre in height, and of an equal diameter, and exhibited a very milky-white hue. And, finally, a third variety—only one—had become visible. This was much flatter, larger in circumference, and showed a decidedly pinkish tinge.

On blood serum, after the expiration of the fourteen days, a good deal of liquefaction was present, and a strong, disagreeable odor, like that of decaying animal matter, was very noticeable. The translucent colonies had thriven better than those cultivated on the agar, while the contrary was true of the pin-point, milky-white ones. The latter appeared on the blood serum to be flatter, not so round, and not so great in diameter. The third pinkish colony had not manifested itself on the blood-serum medium.

On the fourteenth day after the original inoculations had been made, portions of the three colonies on the agar were transferred to tubes of bouillon, and at the expiration of twenty-four hours, in the incubator at 37° C., they were examined. The reinoculation from the

flat pink colony showed a slight sediment and a turbulent bouillon; that from the dome-shaped growth a considerable sediment and a clearer bouillon; and that from the translucent colonies a slight sediment and a fairly clear supernatant fluid. From these sediments cover-glass preparations were made, which showed the flat pinkish and the flatter translucent colonies to be formed of the *Staphylococcus pyogenes albus*, while the unusual dome-shaped growths were due to the *Streptococcus pyogenes*. It is curious to note that these colonies are somewhat atypical.

The result of the planting of several of the patient's hairs upon Sabourand's medium for the cultivation of tinea trichophytina was as unsatisfactory as had proved the inoculations from the nails. After a week in the incubator at 30° C., the Erlenmeyer flasks were removed, and the surfaces of the medium appeared devoid of any vegetable growth whatever.

The microscopical examination of the hairs was next undertaken. The hairs were first looked at unstained, but no pathological lesions could be seen. The microscope revealed no nodes, no rings, no air bubbles, no splitting in the shafts or at their extremities—in fact, the shafts presented only the characteristics of normal blond hair. The hairs were then stained according to the method recommended by Adamson, of London. The process is a simple and clever modification of the Gram-Weigert method, and is very well suited for the differentiation of the spores and the mycelium of the various hyphomycetes and other vegetable parasites. The various steps were these: The hairs were soaked for a half hour in a ten-per-cent solution of caustic potash, and then washed in fifteen-per-cent alcohol for a few minutes. After drying with filter paper the hairs were stained for twenty minutes in aniline-gentian-violet, then placed for five minutes in Gram's iodine solution, and finally left for three hours in pure aniline oil. When this time had elapsed, the hairs were again dried with tissue paper and mounted in Canada balsam. Unfortunately for the interest of the case, examination of the stained specimen showed no parasites, and my last hopes from a bacteriological point of view were gone.

On noting carefully the characteristics of the present disease we are struck by three cardinal points: First, heredity; secondly, changes in the nails; and, thirdly, alterations of the hairy growth upon the body.

In four generations of this man's family, seven men at least have shown a peculiar defect in the well-being of the nails and the hair. Such a family history can not be explained scientifically by coincidence

alone. There is undoubtedly some invisible and as yet undiscoverable causal agency at work.

In the experience of dermatologists thus far we find the following diseases in which anomalies of the nails have occurred: Atrophoderma neuriticum ("glossy skin"), chronic cardiac affections, various coccogenic disturbances, diabetes mellitus, eczema, elephantiasis, erythema, hemiplegia, lepra, lichen ruber, locomotor ataxia, Morvan's disease (syringomyelia?), Norwegian scabies, pemphigus, pityriasis rubra of Hebra, psoriasis, pulex penetrans, chronic pulmonary troubles, Raynaud's disease, rheumatism, scleroderma, syphilis, tinea favosa, tinea trichophytina, and yaws. Rare cases have also occurred after vertigo and clonic convulsions,* after hysteria,† after severe fright,‡ after typhoid fever, scarlatina, and variola.# Thus, in considering from an ætiological standpoint any given pathological condition of the nails, one must bear in mind all the various diseases enumerated above. In the case of this patient I think we can not satisfy ourselves that any of these possibilities lie at the root of his condition. The freedom from any past or present illness which could be discovered by questions, by careful and minute physical examination, or by microscopical or bacteriological investigations, obliges us to seek still further for some positive and conclusive determining factor for our patient's onychia. Of course, one can never eliminate absolutely some syphilitic taint, but surely in the fourth generation one would hardly expect such a diathesis to be increasing rather than diminishing.

Secondly, we look to the hair to see if, perchance, this appendage of the skin can aid us in discovering the cause of this man's inherited peculiarity. In the foregoing pages we have seen that the essential condition of the hair was a dystrophy—all other pathological states, such as atrophies, hypertrophies, parasites, etc., being absent. In turning again to the literature, we find that authors have described many causes for dystrophies of the hairy growth; but, as in the case of the nails, we must again cast these possibilities aside because of the previous examinations of the case, and seek further for the true cause. Unfortunately, I must confess that I am unable to propose any satisfactory and scientific reason for this obscure and interesting dyscrasia.

In concluding this report, all that can be positively asserted is that we have been considering an inherited dystrophy of the hair and the

* De Sanctis. *Sperimentale.* Firenze, 1887, vol. lx, p. 31.

† De Falcone. *Giornale italiano delle malattie veneree e della pelle*, 1887, p. 206.

‡ J. Leslie Foley. *Boston Medical and Surgical Journal*, 1887, p. 301.

J. V. Shoemaker. JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, September, 1890, p. 334.

nails which is now presenting itself in the fourth generation of this family. Such an inherited chain of symptoms has been observed (as far as I can ascertain) in only one series of patients before in literature, and then in a most extraordinary similarity to our case. "Thurman * recorded a case of two cousins who had only a slight lanugo growth of hair on the body and head, only four teeth (molars), and who never perspired or shed tears." † But this was only in two individuals of the same generation. I regret exceedingly that I have been unable to discover some definite cause for this peculiar constitutional disease, which must be left to conjecture. As for a title for this rare condition, I would suggest the purely symptomatic one of dystrophia unguium et pilorum hereditaria.

FORMALIN IN GONORRHŒA.

By GEORGE T. HOWLAND, M. D.,
Washington, D. C.

SOME time ago my attention was called to the use of formalin as an antiseptic of the first class. Seeing a number of cases of gonorrhœa, I made up my mind to give it a test. With this end in view I append six cases. These are not selected cases, but just as they came to my office.

I started with a five-per-cent solution, but I found it too strong; it was almost caustic in its action. I immediately injected a pint of normal saline solution, hot, 100° F., and in the rest of the irrigations I used only one-half-per-cent solutions. Unfortunately, all the cases were acute anterior gonorrhœa. In all the cases the secretions were examined daily for the gonococci, careful tests being made with the Gram Roux method. In each case the gonococci were found. The method I used was the following: Introduced Stein's urethral irrigators as far as the bulb. Then passed a soft rubber catheter within the irrigator and connected it with the tubing of Dr. H. Holbrook Curtis's heating apparatus. Never allowed the temperature to go above 100° F.

For the first two or three days irrigations of one quart of the hot formalin solution were given twice daily; afterward once daily until discharge ceased to contain the gonococci.

* Thurman. *Med.-Chir. Trans. of London*, vol. xxxi (1848), p. 71.
† Crocker. *Diseases of the Skin*, p. 794, edition of 1893.

No internal treatment was given except regulating the bowels. I used the compound cathartic pills—two pills twice a week.

All highly seasoned food, alcohol, tea, and coffee were prohibited.

Advised the ingestion of from two to four quarts of pure water in the twenty-four hours. Most of the patients used Poland Spring water.

There was one peculiar characteristic that was noticed in regard to the action of the irrigating fluid on the gonococci. They "shriveled up" and lost their form. Especially was this marked if they were free in the pus, not within the cell.

Case I.—February 15, 1896. J. W. W., aged twenty-five. First attack. Microscopical examination revealed the gonococci.

Decolorized by Gram-Roux.

One quart of one-half-per-cent formalin solution was used twice daily for three days.

Then only one quart was used daily until February 28, 1896, when discharge had ceased.

He returned as requested on March 4th, but reported no return of discharge.

Case II.—W. McC., aged twenty-nine. Second attack. First, four years ago. Irrigations were commenced on February 22, 1896, and continued until March 6, 1896, when they were stopped, as no secretion was present. Patient has disappeared; have not seen him since.

Case III.—P. G. (colored), aged twenty-six. Second attack. First attack eight or nine years ago. Irrigation commenced on February 29, 1896. March 13th, ceased treatment, as discharge had ceased. Saw him since; reports no renewing of discharge.

Case IV.—W. L., aged twenty-one. First attack. Irrigation commenced on March 7, 1896. Discharged him March 22, 1896. Secretion disappeared on March 21, 1896, but continued irrigation one day longer. Returned on March 25th; reported no discharge. Is to be married shortly, and was afraid he was not cured. Gave him two drachms of bichloride, two per cent, a hand syringe to throw the solution in his urethra on retiring, and also to drink a couple of bottles of beer, and to report at the first appearance of pus. Forty-eight hours after, reported no discharge. Saw him on April 16, 1896, but has had no return of the disease.

Case V.—T. W. B., aged thirty-eight years. Third attack. Commenced irrigation March 10, 1896. Discharged him April 7, 1896. Saw him on April 15th; reports no discharge in the interval.

REPORT OF A CASE OF PHAGEDENIC CHANCROID.

By EDWARD R. OWINGS, M. D.,
Clinical Assistant, Genito-Urinary Department, Johns Hopkins Hospital.

PATIENT applied October 17th, for treatment, giving history of ulcers on penis for three weeks, during which period he had treated the same with black wash.

Examination.—Prepuce long but readily retracted. Glans penis and mucous prepuce studded with small superficial ulcers, varying in size from head of pin to five millimetres in diameter. Secretion free and purulent. Glands in groins not enlarged.

Ulcers thoroughly cauterized with fuming nitric acid, six per cent cocaine muriate used as anæsthetic. Hot bichloride irrigations (1 to 20,000), and dermatol, three times a day, as treatment.

October 20th.—Ulcers have increased in number and are larger in size than before noted. *October 22d.*—Ulcers spreading. Patient anæsthized (ether), and entire surface of glans penis and mucous prepuce thoroughly gone over, each ulcer being cauterized, the surface dried, and then recauterized with pure acid nitric. *October 23d.*—Patient unable to retract prepuce; free purulent discharge from preputial cavity; no glandular enlargement. Irrigation as before with hot bichloride (1 to 20,000). *October 25th.*—Penis much swollen; phimosis marked; free purulent discharge from preputial cavity; odor very offensive. Prepuce slit; ether anæsthesia.

Instead of numerous small ulcers, mucous surface of prepuce entirely and greater portion of glans penis are involved in one large ulceration. Frenum is destroyed. Ulcer is covered with dirty-grayish membrane, which, when removed, leaves dirty irregular base. Dorsal incision and ulceration thoroughly cauterized. For two or three days disease seemed to be held in check. Surface looked healthy after separation of slough, and discharge was slight. Pain also ceased, and patient was able to sleep. *October 30th.*—Ulcer larger, borders dusky, discharge copious. Patient losing flesh and strength. Again anæsthetized and thoroughly cauterized with nitric acid, especial attention being directed to edges of ulcer.

November 3d.—Ulcer after separation of slough still dirty. Discharge copious, edges gradually extending. Began spraying three times daily with peroxide of hydrogen. This was followed by some apparent improvement; base of ulcer appeared more healthy. Discharge diminished, and patient was able to rest at night. Pain, which

was of burning character, relieved. Borders of ulcer, however, continued to extend slowly, had dusky hue, and on glans penis, right side of dorsum, a small ulcer developed and gradually increased in size. Cauterization again advised—this being the fifth cauterization and fourth general anæsthesia. Patient being asleep, a rubber catheter was tied tightly around penis to control bleeding, and entire ulcerated surface thoroughly curetted; edges especially vigorously scraped. Surface was then cauterized with nitric acid. Though there had been no evidence of any intra-urethral ulcer, the possibility of the same as a means of infection suggesting itself, meatus, and urethra to depth of one half to three quarters of an inch cauterized with nitric acid.

After this cauterization glands in both groins enlarged, and were quite tender for two or three days. In four or five days slough separated, revealing unhealthy surface, discharge free and purulent. Entire prepuce is now destroyed, and greater portion of glans involved in ulceration. Small ulcer on glans, which was last to develop, has increased in size.

Cauterization once more advised. Patient anæsthetized. Procedure as before. Entire surface curetted. Free edge of ulceration, both on glans and border of prepuce, removed with scissors, thus destroying still more of his now scanty prepuce. Edges thus created, though healthy in appearance, carefully curetted, base of ulcer again curetted, and entire surface cauterized with nitric acid. Slough did not separate for eight days. When it did, showed healthy granulating surface. Hot bichloride irrigations (1 to 20,000) continued three times a day. Ulcer healed without any further difficulty, but so large was the area involved that the entire surface had not cicatrized until January 3d. Patient has now a very much deformed but serviceable penis. Greater portion of glans penis is present; frenum of course is destroyed, as is prepuce. Only one cover slip, made of discharge from ulceration. This showed, besides ordinary pyogenic organisms—viz., *staphylococcus aureus*—a bacillus similar to the bacillus described by Ducrey as pathognomonic of chancroid.

The noninvolvement of glands is interesting, though it has been my observation that where there are large phagedenic chancroids there is generally no bubo. The important measure in these cases is to extend the cauterization to seemingly healthy tissues, as the organism is always present some distance beyond the edge of ulcer.

Prompt and thorough cauterization is the only efficient method of treatment.

Society Transactions.

THE NEW YORK DERMATOLOGICAL SOCIETY.

251st Regular Meeting, held on Tuesday Evening, March 24, 1896.

Dr. C. W. Cutler, *President*, *in the Chair*.

A Case for Diagnosis.—Presented by Dr. S. Sherwell.

The patient, Mrs. S., aged forty-two, first came under the doctor's care in January, 1887; was presented at a society meeting shortly afterward, with a condition resembling lymphangitis of both cheeks and nose. Had syphilis previously, probably two or three years before, and several miscarriages. No periostitis then manifest. Under ordinary treatment for her trouble, the symptoms in general, and those of the face in particular, subsided. A condition of atrophy of skin to some degree, but much greater of fat and subcutaneous and even muscular tissue, resulted and slowly progressed, so that now she has the "*tête de mort*" appearance, as shown. Her general health is now good; she was confined of a relatively healthy male infant soon after treatment had been kept up awhile; this child is now a healthy and vigorous boy of about six years. The case at one time seemed to simulate a myxœdema, but there is and was no abnormity of the thyroid gland, and she is a normally bright, cheerful woman, who makes as light of her cosmetic defects as is possible for one of her sex. All that seems to be positive in the case, in his opinion, is a blocking of lymph channels, and consequent nutritive degeneration.

Dr. C. W. Allen said that he had no diagnosis to offer. He had never seen syphilis produce such an effect. There appeared to be an absorption of the subcutaneous fatty tissue, without any apparent atrophy of the muscles or skin.

Dr. George T. Jackson said he had never seen a case similar to this one. He did not know what the condition was due to.

Dr. A. R. Robinson said he could not venture a diagnosis. The condition was probably due to some affection of the lymphatic structures. The muscles and epidermis seemed to be normal.

Dr. Bulkley said that some time ago he saw a patient with unilateral atrophy of the face. In that case, as in the one shown by Dr. Sherwell, there was a specific history, and he supposed that the atrophy was due to syphilitic nerve implication.

Dr. Sherwell, in closing the discussion, said he did not know whether the lesions had any connection with syphilis or not. The woman otherwise appeared to enjoy good health. The origin of the trouble, he thought, was a lymphangitis.

A Case for Diagnosis.—Presented by Dr. Fox.

The patient was a middle-aged woman with a number of indurated masses on either cheek, on the nose, and on several fingers. The masses consisted of

a subcutaneous induration, and the integument covering them had a reddish and at times a purplish hue. The lesions began to develop, one after the other, about four years ago. The woman's general health appeared to be good. Antisyphilitic treatment had thus far produced no effect on the lesions.

DR. ROBINSON said he regarded the eruption as a gummatous syphilide. The œdematous condition of the fingers was probably secondary, and due to a lesion higher up.

DRS. BULKLEY and SHERWELL also made a diagnosis of gummatous syphilide.

DR. ALLEN said that even in the absence of any history of syphilis he would not hesitate to pronounce the lesions in the case shown by Dr. Fox specific, and he would not abandon that idea unless a very thorough course of antisyphilitic treatment extending over many months, or possibly a year, had been tried and failed.

DR. GEORGE T. ELLIOT said the case represented to him one of syphilis. These lesions were often very rebellious to treatment. In a similar case coming under his observation about nine years ago, the lesions finally improved under mercurial inunctions. The speaker said this would be a good case in which to test the value of injections of gray oil or calomel, a method of treatment which had been very successful in the hands of Le Pileur, Feulard, and others.

DR. R. W. TAYLOR said that he was averse to making a diagnosis in any case until the history had been carefully looked into. The appearances of these lesions were strikingly typical of diffuse and nodular syphiloma of the face. He thought that inunctions, with the iodide internally, would cause the infiltration to disappear.

DR. S. LUSTGARTEN regarded the case as syphilitic. Cases like this, he said, had been cured before gray oil was known, and a thorough application of the older methods of treatment would probably effect a cure in this instance.

DR. FOX, in closing the discussion, said his first impression was that the case was one of syphilis. Since then, however, he had seen the patient a number of times, and had become somewhat doubtful regarding the specific nature of the lesions. They had a peculiar purplish color, differing from that of any syphilitic lesions he had ever seen. He stated that he would push the specific treatment, if necessary resorting to inunctions or hypodermic injections of gray oil, and report the result.

A Case of Epithelioma treated by means of Injections of the Toxines of Erysipelas.—Presented by DR. DANIEL LEWIS.

The patient was a man aged forty years, who about three years ago developed an epithelioma of the lower lip which was removed by some kind of caustic application. About a year later recurrence took place in the cervical glands, and when he came under Dr. Lewis's observation about a month ago the disease had progressed to such an extent that a radical operation was impossible. It was then decided to try the effect of the erysipelas toxines. Gibier's preparation, known as the double toxines of erysipelas, was first employed, and afterward the new preparation made by Dr. Coley. At the point of each injection an abscess forms, which softens and discharges, and in this way the epithelioma is gradually being reduced in size.

DR. LUSTGARTEN said that while a good deal had been heard about im-

provement through the toxine treatment of malignant disease, he had never seen a single case in which a cure was effected. In three or four cases coming under his observation, which were reported as cured, the patients finally died of their malignant disease. In one case of his own, of granuloma fungoides, the toxine treatment failed completely.

Dr. Elliot said that, so far as his experience went, the toxine treatment was of little avail. In cases of sarcoma in which it was employed, and which he knew of, the patients died within six months of that disease, although the original growth seemed to have undergone resolution.

Dr. A. R. Robinson said he had seen some of the cases treated by Dr. Coley with erysipelas toxines. He had never seen a single case of cancer that had been benefited to any special extent by that treatment. An injection or use of any substance that will effect a rapid change in the nutritive condition of the tissues of the body generally will often temporarily, retard the progress of a malignant growth, or may even cause it to diminish in size. It is a well-known fact that a superficial cancer will permanently disappear by the irritant (inflammatory) action of certain applications. So the injection of erysipelas toxines may check the cancerous growth for a time, until the organisms accommodate themselves to the changed nutritive conditions, and similar results can be obtained by other means, as he had often observed in his studies on cancer. He would not think of using erysipelas toxines in any case of cancer.

Dr. Elliot said that eight or nine years ago the Germans reported just as good results for a certain length of time from hypodermic injections of osmic acid. The injections simply produced a temporary effect, but were finally given up.

Dr. Allen spoke of pyoktanin and the aniline dyes which have been employed for the same purpose. In one case of inoperable sarcoma and two of epithelioma in which he had used this remedy by interstitial injection, a wonderful improvement was noted; it proved to be only temporary, however, and all three of the patients died.

Dr. Fox said that in a number of cases of lupus erythematosus and vulgaris, and in one case of epithelioma, he had employed injections of pilocarpine, recommended by Dr. Waldstein for tuberculosis. The drug was given in doses of one twentieth to one tenth of a grain, and produced a reaction similar to that of Koch's lymph. In the cases of lupus there was no very great or beneficial result, but in the epithelioma a remarkable change was noticed. The growth, which had been there for years, softened perceptibly within two or three weeks, and its elevated, hardened margin had flattened down. In all, about ten or twelve injections were given. The patient is still under the same treatment, but the improvement seems to have ceased.

Dr. Lustgarten said that Esmarch explains the cures reported by Coley on the ground that the cases were not sarcoma, but syphilis. In syphilitic lesions a temporary or even permanent cure by means of the toxines would not be so surprising.

Dr. H. G. Piffard said that in one case of supposed malignant disease where he was consulted as to the advisability of employing the toxine treatment, he advised against it. In a case of generalized scrofulosis coming under his observation he used iodohydrargyrate of pilocarpine (which is a very expensive preparation) with decided benefit.

DR. ELLIOT said he was surprised to learn that Dr Lewis had any faith in the toxine treatment, as it was only a few years ago since he read a paper on this subject in which he expressed the view that cases of epithelioma or cancer should be treated by the most heroic measures, and that mild treatment only stimulated the growths into greater activity.

DR. LEWIS said he had in no sense changed his views on this subject. He had never employed the toxine treatment in any case where other measures were possible, and he had very little faith in it. His experience with the remedy had been unsatisfactory, excepting in one instance. This was the case of a man who consulted him about a year ago for an abdominal tumor on the right side, below the gall-bladder. He had been operated upon by a surgeon who made an incision over the growth and then found that it could not be removed. The wound was accordingly closed. The surgeon stated that from the appearance of the growth he believed it to be malignant; he failed, however, to take a section for microscopical examination. Injections of erysipelas toxines were then commenced, and continued for about four months. When he was last seen by Dr. Lewis, about six months ago, the tumor could not be felt, and the man was so well that he had resumed his business. This was the only case coming under his observation in which decided improvement followed the treatment. As no microscopical examination was made, the diagnosis was open to doubt. Dr. Lewis said he had employed the aniline preparations in a number of cases with the same improvement which had been reported from the employment of these toxines—temporary benefit.

DR. PIFFARD said he had experimented with some of the aniline colors, to learn their effects on low forms of life. He found that infusoria seemed to thrive on neutral red, and swam around in the solution after they were fully stained.

DR. MORROW stated that last summer a man entered the New York Hospital with numerous fungating tumors on the body and extremities which were supposed to be malignant. He also developed a large abscess on the inner aspect of the right thigh. This was incised and allowed to suppurate freely. As a result of this, the tumors entirely disappeared, and, in addition, the glands in the groin, which had been much enlarged, resumed their normal size. There had been no recurrence of the tumors. Had this patient been subjected to the toxine treatment, the case would no doubt be included among the cures that have been reported.

DR. ELLIOT said that the erysipelas toxines had been highly recommended in the treatment of lupus; it is doubtful, however, if they are of much value in this disease. Hebra and Kaposi long ago called attention to the fact that subjects of lupus were peculiarly subject to erysipelas, but the attacks did not seem to exert any curative effect upon the pre-existing disease.

DR. A. R. ROBINSON reported the following case, which came under his observation last August: The patient was a resident of Chicago, where he had consulted a well-known surgeon for a tumor of the rectum, which was regarded as malignant, the diagnosis of sarcoma having been made after a microscopical examination of the growth. Two unsuccessful operations were performed, the growth returning after each operation, and the man was then sent on to New York, where he expected to undergo the erysipelas treatment. He happened to fall into Dr. Robinson's hands, who, on stripping

him, found the remains of an old syphilide on the soles of the feet. Under specific treatment, the growth in the rectum entirely disappeared. This case is reported to show how easily such a case could be reported as a case of sarcoma, cured by a toxine injection, owing to a mistaken diagnosis

Dr. Allen said he had seen a case of lupus erythematosus of the face in which there was for a time marked improvement, amounting to apparent cure, which followed accidental infection with erysipelas.

Dr. Elliot said that in his remarks he referred to lupus vulgaris, not erythematosus.

Dr. Piffard said he had seen a case of lupus erythematosus permanently cured after a facial erysipelas.

Dr. Lewis said that while visiting the Cancer Hospital in London last summer he was informed that the toxine treatment of cancer had been tried there and abandoned, because it was considered dangerous. They had at least two deaths as a direct result of the treatment. It was his conviction that the time had arrived when an authoritative statement should be published, discountenancing the employment of this remedy, which accumulated experience had already proved to be of doubtful value, if not positively harmful in a vast majority of cases.

A Case of Lupus Erythematosus of the Ears and Scalp.—Presented by Dr. Klotz.

Mrs. M., twenty-six years of age; a Polish Jewess; married six years; has had three children; the youngest ones, twins, were born four years ago and died when they were a few weeks old. The patient has an eruption which appeared about nine months ago. When she was first seen (November 25th) at the German Dispensary she showed lesions in about the same condition as those now apparent on both ears in the center of the concha and on the top of the scalp, excepting that they were covered with dry, hard, firmly adherent, thin crusts. After removal of these, the skin appeared atrophied or slightly cicatrized.

Since December the patient has been complaining of severe pain in the spot on the scalp. She refuses to take iodide of potassium, on the plea that it does not agree with her. The lesions have not been materially affected by white precipitate and other ointments, except that the formation of crusts has been prevented and small erosions have appeared. The lesions resemble lupus erpthematosus more than any other disease.

Drs. Jackson, Elliot, Bronson, and Lustgarten agreed that the case was one of lupus erythematosus: also Drs. Sherwell and Allen.

A Case of Urticaria Pigmentosa.—Presented by Dr. Cutler.

The patient was a girl aged eighteen years, a native of England. She presented numerous small round spots of pigmentation of the skin on the trunk, face, and extremities. Her mother stated that these spots first made their appearance after an attack of measles when the girl was three weeks old, and had since persisted. There never had been subjective symptoms, and the skin was not irritable at present.

Drs. Allen and Jackson regarded the case as one of urticaria pigmentosa.

Dr. Morrow said he did not regard the absence of urticarial symptoms as a contraindication to the diagnosis of urticaria pigmentosa. In a number of cases on record no subjective symptoms were present. At the last meeting

of the French Dermatological Society a case was reported in which the absence of factitious urticaria was noted.

DR. LUSTGARTEN regarded the case as one of urticaria pigmentosa of medium intensity.

DR. CUTLER said he thought there was hardly any doubt that the case was one of urticaria pigmentosa. The attack of measles which the mother states the child had in early infancy was probably a severe attack of urticaria; since then there has been an entire absence of urticarial symptoms, which is a rather unusual history in these cases.

DR. ELLIOT regarded the case as one of urticaria pigmentosa. In a case reported at the French Dermatological Society the lesions first appeared at the age of ten years, and Kaposi has reported a case at an older age. Some years ago, Dr. Elliot said, he showed a man thirty-two years old in whom the disease had only existed four years; by rubbing the pigmented spots on that patient wheals could be produced. Under the microscope the same features were seen as occurred in urticaria pigmentosa which had begun in infancy. The speaker said he differed decidedly with the opinion expressed by Dr. Crocker that the case referred to was not one of urticaria pigmentosa; he thought it perfectly possible that the disease might begin as late in life as in the case mentioned, namely, at the age of twenty-eight.

DR. LUSTGARTEN said that while in Vienna he saw the case reported by Kaposi. The patient was a girl fifteen or sixteen years old, very dark-complexioned—a typical case of urticaria pigmentosa.

DR. JACKSON exhibited photographs of a case of folliculitis decalvans. (Will appear later in this JOURNAL.)

THE NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY. STATED MEETING, HELD ON TUESDAY EVENING, APRIL 14, 1896.

DR. W. K. OTIS, *Chairman*.

A Case of Tumor of the Testicle.—Presented by DR. R. GUITERAS.

The patient was a boy, nineteen years old, with a tumor of the right testis. The growth made its appearance about forty days ago, and was situated in the globus major of the epididymis. There was no venereal history; no traumatism; the family history was negative. The tumor was slightly painful to the touch and on motion. Dr. Guiteras said he presented the case for diagnosis.

DR. BANGS said that, while he did care to venture a positive diagnosis, he thought the lesion was an interstitial epididymitis in the globus major.

DR. EUGENE FULLER thought the trouble was inflammatory—probably a tubercular exudate.

DR. J. R. HAYDEN said the tumor seemed to have a cystic feel.

DR. J. A. FORDYCE was inclined to regard the lesion as tubercular.

DR. H. G. KLOTZ said he did not think a positive diagnosis could be made at present. The growth might be syphilitic or tubercular, or a simple inflammatory exudate.

Dr. Pollitzer suggested that aspiration be resorted to in order to ascertain its true character. It was possible that the growth was sarcomatous.

Dr. Guiteras said, in conclusion, that although he considered the case as probably one of tubercular epididymitis, yet he did not feel sure that it was not a beginning sarcoma. It was not at all typical of tubercular epididymitis.

A Case of Carcinoma of the Rectum.—Presented by Dr. H. Lilienthal.

The patient was a man, forty-nine years old, who first came under his observation last June. At that time his disease had existed for about a year. He was subjected to vigorous antisyphilitic treatment, without any resulting benefit. An operation was accordingly undertaken to excise the growth, which was very extensive, involving not only the rectum, but the ischio-rectal fat and perineal tissues. There was so much infiltration in the neighborhood of the urethra that all the tissues had to be removed excepting the mucous membrane. The lumen of the urethra was not invaded. There was an unusual amount of hæmorrhage, which necessitated haste in operating, and some infiltrated tissue was left behind. The operation was performed over nine months ago, and there has been no local recurrence, and during the past six months the man has resumed his work as a plasterer. The veins over the abdomen are distinctly swollen, which probably points to a recurrence in the liver or retro-peritoneal glands.

Dr. Fuller said he had listened with much interest to the report of Dr. Lilienthal's case. He did not think it probable, however, that the original mucous membrane of the urethra remained intact after the operation. He was more inclined to believe that sloughing occurred, as it is very apt to do in such cases, and that in the resulting cicatrix there was a formation of pavement epithelium, which now forms a part of the urethral canal.

Dr. Lilienthal, in reply to Dr. Fuller, said he had no reason to suppose that any sloughing whatsoever occurred after the operation, nor was there any urine leakage. A soft catheter was left in the urethra and the wound was allowed to granulate.

A Case of Chancroids about the Anus.—Presented by Dr. Guiteras.

The patient was a young man with a number of chancroids about the anus, of four months' standing. He denied ever having indulged in unnatural sexual practices, and gave a history of their development shortly after the appearance of similar ulcerations on the penis following coitus.

Dr. Guiteras said that, although authorities usually claimed that chancroidal ulcers in this locality were due to pederasty, he did not see why they might not possibly be due to auto-inoculation, as there was such a proximity of the two parts, and probably such a careless handling of them while at stool.

Dr. Fuller said that about three months ago he had had this patient under his care. The man then admitted that he had been approached by the rectum.

Dr. Hayden said the man had made a similar admission to him.

Dr. Janet's Sterilizable Syringes.—Dr. J. Van der Poel exhibited a number of Dr. Janet's syringes, one for bladder washing, another for the introduction of cocaine into the urethra, and a third for instillations. The first two are made entirely of metal, while in the third the barrel is made of glass. All three of the instruments may be sterilized by boiling.

The Chairman said he had employed Janet's syringes for several months

and found them very satisfactory, particularly the large one for bladder washing. One objection to it is its weight.

DR. VAN DER POEL suggested that the instruments might be made of aluminum.

The Genito-Urinary Tract of a Hermaphrodite.—(Post-mortem specimen.) Exhibited by DR. F. FERGUSON.

The speaker said he did not present this as a genuine specimen belonging to the classification of hermaphrodite. The specimen was removed from a person forty-four years of age, who, during life, while possessing certain peculiarities, was always regarded as a perfect woman. Her occupation was that of a cook. She always dressed as a woman. She had a masculine voice and shaved regularly. During the six days that she was an inmate of the hospital she developed quite a strong stubby beard. She also had considerable hair on the chest. The breasts, while they were larger than those of a man, were not very well developed. On the autopsy table the body resembled that of a man, with the exception of the development of the pelvis, which was practically a female pelvis. The cause of her death was chronic diffuse nephritis, with an acute attack superadded. The genital organs were those of a female, but anteriorly there was projecting a rudimentary penis, about half an inch long and very perfect in its formation. The uterus, ovaries, tubes, and vagina were found to be normal. No traces of testicles could be found.

DR. BANGS said it was an interesting fact that there was no such thing as a true hermaphrodite. Either one sex or the other predominates. The speaker said he had examined many of these specimens in the museums of Paris, and while in some of them the penis was much larger than in the one shown by Dr. Ferguson, yet the other genital organs made the woman predominate.

A Kidney with an Anomalous Blood Supply.—(Post-mortem specimen.) Exhibited by DR. EUGENE FULLER.

The kidney was removed from a man seventy-two years old, who died of acute suppression of urine eighteen hours after an operation for the relief of a very tight stricture. At the autopsy one kidney was found to be normal; the other was very much disorganized, hardly any of the cortical substance being left. The organ presented several anomalies. The pelvis was made up of half a dozen ramifications of the ureter, instead of being composed of one compartment, as usual, and the renal artery, instead of entering at the hilum, was divided into several branches which entered directly into the substance of the kidney on either side.

DR. FERGUSON regarded the specimen as a very interesting one, on account of the ramifications of the ureter. An anomalous distribution of the blood supply of the kidneys, he said, is not very infrequent.

DR. GEORGE E. BREWER said that in the dissecting room he had seen a number of cases in which the blood-vessels entered directly into the substance of the kidney instead of at the hilum.

The Common Treatment of Syphilis.—DR. R. H. GREENE read a paper on this subject. He confined his remarks principally to the treatment of syphilis as it presents itself under the following conditions :

1. Syphilis as it occurs ordinarily and runs a moderately typical course.
2. Syphilis as it occurs in old age.

3. Syphilis as it occurs in those whose constitution has been or is depraved through some noxious influences.

4. Some of the manifestations of syphilis of the nervous system.

The speaker first called attention to the importance of becoming thoroughly acquainted with the patient's constitution, which has a great influence in determining the course of the disease. He recommended very simple treatment for the local lesion. Usually some soothing, antiseptic powder is all that is necessary, and is preferable to the application of destructive substances, which may destroy a valuable evidence of the real nature of the disease, or may leave upon the penis a scar which may be considered later in life as proof positive to show the previous possession of an indurated, specific ulcer.

On the first appearance of constitutional manifestations, the active treatment directed toward the cure of the disease is begun by the administration of mercury. When there is no æsthetic or constitutional objection to the use of inunctions, this method is preferred. Next to inunctions, the speaker said he favored the internal administration of the protiodide of mercury. If the drug, thus administered, is not well borne, recourse should then be had to calomel, to fumigations, or by reversion to the inunctions. Patients should be seen frequently, and attention given to hygienic measures, exercise, etc.

In syphilis occurring in a patient above forty, the physician's first duty is toward improving the general health. This should be done most assiduously in the interval that elapses between the appearance of the initial lesion and the first constitutional manifestations. In these cases, mercury should not be pushed with the same vigor as it is in the young, and it should be combined from the start with a tonic plan of treatment.

In those whose constitutions have been depraved through some noxious influence the disease usually runs a very severe course. In alcoholics the destructive tendency of the primary ulceration is frequently best checked by the early administration of constitutional remedies and, in addition, strychnia given up to the physiological limit. Patients addicted to the morphine or cocaine habit are extremely liable to severe syphilitic manifestations. In these cases it is wise to administer mercury hypodermically, while no attempt is made to interfere with the drug habit. After the activity of the syphilitic virus is controlled, there will be plenty of time to counteract the effects of the opium or cocaine and give moral treatment.

Syphilitic meningitis and neuritis are the two common inflammatory conditions of the nervous system, and call for active antispecific treatment. In these cases, in addition to securing the constitutional effects of mercury as soon as possible, whether it be by inunctions or hypodermic injections, it is wise to apply mercurial ointment locally over the seat of the disease.

Before concluding his paper, Dr. Greene referred to the use of iodide of potassium in the treatment of syphilis. In his estimation it would be far better to say that iodide of potassium is of absolutely no value in the treatment of syphilis than to further the opinion that it is a specific. It is of great value in treating the results of syphilis, such as tissue fibrosis.

Dr. George T. Elliot said he fully agreed with the statement made by Dr. Greene that in the treatment of a patient with syphilis we must be guided by the conditions met with in each individual case. We must treat the syphilis, plus any other disease the patient may have. Mercury is the

most valuable drug at our command for the purpose of effecting a cure in syphilis—that is, putting the patient in such a condition of health that he is practically free from symptoms. Potassium iodide is of value in cases of long standing, but mercury, used for a considerable time and with proper intermissions, is the only drug which has any curative effect. The speaker said he had seen so many cases in which recurrences took place after many years, even in patients who were faithfully treated for two or three years, that he felt very doubtful whether syphilis was ever entirely eradicated. We may render it innocuous, but that we cure it is an open question, which must be settled by individual cases.

As regards treatment, Dr. Elliot said he preferred the inunction method where it can be faithfully carried out. He is opposed to the use of the protiodide, which is apt to give rise to colic, diarrhœa, and salivation, while in some cases even very large doses seem to have no effect whatever.

DR. P. A. MORROW said that while there is a great difference of opinion among physicians regarding the treatment of syphilis, it is generally conceded that constitutional treatment should not be commenced before the advent of constitutional symptoms, and that it should be continued for a long time. This period should correspond to the natural life-term of the disease, namely, from three to four years. It is desirable to intermit the treatment from time to time to prevent the disorders which follow the continuous administration of mercury, and also to prevent the exhaustion of the action of the drug by habitude. The speaker said he quite agreed with Dr. Greene in regard to the desirability of studying the peculiarities of each individual case, and adapting the treatment—as far as we intelligently can—to such peculiarities. It is a mistake to assume that all the symptoms which develop in the course of syphilis are due to the syphilitic virus. A certain contingent of these patients may be anæmic, or scrofulous, or rheumatic, or nervous, and it is necessary to treat these conditions in addition to the syphilis. Syphilitic patients who fall a prey to nerve lesions are probably predisposed to nervous trouble; syphilis is probably not the sole ætiological factor.

The speaker said that, contrary to Dr. Elliot's experience, he had found the protiodide very efficient in the treatment of syphilis, and he employed it in the majority of the cases coming under his care. He had not found that it is apt to give rise to colic, stomatitis, etc. He did not approve of inunctions as a routine method of treatment. While it was, no doubt, an excellent method, it was objectionable to many private patients from an æsthetic standpoint; it is apt to be improperly carried out, and it not infrequently gives rise to stomatitis.

Dr. Morrow said he did not agree with the two previous speakers regarding the value of potassium iodide in the treatment of syphilis. It possessed a marvelous efficacy in causing to disappear the late manifestations of the disease, and it was also very useful in the earlier stages where pustular eruptions occurred. The value of the drug was often strikingly shown in cases where syphilitic nerve lesions existed.

DR. FORDYCE said that while it is advisable in the majority of cases to postpone constitutional treatment until the appearance of the eruption, yet there are cases where a positive diagnosis can be made previous to that time, and where it is desirable to commence treatment at once. For example, this applies to cases where there is marked anæmia, which begins during the

second incubation period; it also applies to cases where the initial lesion is extra-genital, on the lip or face or about the meatus, when its rapid disappearance is very desirable. Regarding the preparations of mercury to employ, the speaker said we probably get the best results from those containing the most metallic mercury; personally, he preferred the pil. hydrarg., mercury with chalk, or the inunction method. The latter is probably the most rapidly efficacious. At Hot Springs he had treated many cases by the inunction method and it produced ptyalism less frequently than at home. In private practice, for social reasons, the inunction method is not always practicable. The speaker said he agreed with Dr. Morrow that in the treatment of pustular lesions, potassium iodide, combined with mercury, produces excellent effects. Potassium iodide probably exerts a curative effect on the later lesions of syphilis, just as much as mercury does on the earlier ones. We have no proof that potassium iodide does not cure the late lesions of syphilis. Dr. Fordyce expressed the opinion that many of the late lesions of syphilis are purely local, and are the result of the local action of the syphilitic poison on the tissues, just as we see the local manifestations of tuberculosis.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

The Question of the Injection of Mercurial Compounds in the Treatment of Syphilis.—This important question, which I have already several times presented to you, has recently raised an interesting discussion in the French Society of Dermatology; two entire sittings were given up to it. Although the generality of the statements were rather confused, certain conclusions may be drawn which seem to me worthy of being given with some detail

Injections of Soluble Mercurial Compounds.—Injections of soluble mercurial compounds have ardent partisans, especially among the ophthalmologists; they favor bichloride of mercury, mercury cyanide, the succinimide, the benzoate, and the oil of the biniodide. There is no serious inconvenience attending their use; they have the advantage of causing the medicament to pass with certainty and in exact dose into the organism while respecting in certain measure the stomach and digestive canal. Still, they have the great disadvantage of compelling the patients to submit to an injection every day or every other day, and for this reason it is impossible, in France at least, to make this the ordinary method. On the other hand, it is an excellent practice in polyclinic and hospital. These little operations can scarcely be intrusted to the hands of the inexperienced, however; it is preferable to have them done by physicians, and the city patients will always here refuse to return often enough.

Injections of Insoluble Mercurial Compounds.—Injections of insoluble mercurial compounds are free from this objection; they are made every eight, twelve, or fifteen days, according to the case. On the other hand, there have

been seen in their train abscesses, more or less persistent and painful nodules, considerable tumefactions, pain, more or less intense according to the subject and the injection in the same subject, pain which develops on the second to the fifth day after injection, and which sometimes interferes with walking; finally, stomatitis, early or late, more or less grave, and in certain cases (happily rare) serious accidents from general intoxication.

To make them, minute care in antisepsis is necessary; the upper part of the buttock, a little internal to the muscular masses, is the place chosen. The needles should be about five centimetres long, quite strong. The injection should be driven in very slowly.

After all that has been said in the discussion which has just taken place, it does not seem possible that these injections should become the usual method in France, (*a*) because they require too minute care in asepsis to be used with impunity in a routine manner by the mass of practitioners, and (*b*) because they are subject to more annoying and serious accidents than the gastric and cutaneous methods.

Indications for Injections of Insoluble Mercurial Compounds.—It is none the less true that these injections constitute for many rebellious syphilitic manifestations the most powerful means of action of which we are at this moment possessed. Recourse to them should be taken without hesitation when ordinary procedures are not well borne or give insufficient results. Here are the chief indications for these injections according to the various statements made :

1. The *phagedenic chancre of the tongue* (Fournier) and, one may add, by generalization, large phagedenic chancres of syphilis having no tendency to cicatrization.

2. *Malignant, precocious syphilis.* There is, however, it seems to us, a most important reserve to be made in this regard. There are persons attacked with malignant, precocious syphilis who take mercury only with the greatest difficulty. We do not believe that it is prudent to subject them to injections of calomel. If it is proved that the ingestion of mercury aggravates their lesions, it is necessary to abstain from all hypodermic medication. If their stomachs or intestines can not tolerate mercury, a small dose of a soluble mercurial, the oil of the biniodide, for example, might be used. If this product is not well tolerated, recourse may be taken to injections of compound insoluble mercurials, beginning with very moderate doses.

3. *Tertiary glossites*, notably those tending to the sclerotic form. It is not necessary to repeat, with the majority of syphilographers, that this is one of the principal indications for the injections of calomel. They give in these cases, so rebellious to other medication, really marvelous results.

4. The same is true of *lingual* syphilides in secondary form which linger long in certain subjects, notably smokers (A. Fournier).

5. *Grave syphilitic laryngites* (Mendel). They are rapidly modified by calomel injections.

6. *Psoriasiform syphilides*, more or less keratodermic, of the palms and soles. It is sometimes relatively easy to make them disappear by ordinary mixed treatment (inunctions on the one hand, iodide of potassium on the other), aided by local medication, but there are cases in which they relapse with desperate tenacity. Calomel injections give them admirable results as regards rapidity of effect and curative action.

7. The same applies to *tertiary, relapsing syphilides of the face and lips* (Thibierge, Jullien), and in particular to labial psoriasiform syphilides, so often the despair of women and smokers.

8. *Syphilitic affections of the ocular globe*, for which the majority of ophthalmologists prefer injections of soluble mercurials. Among them are (*a*) the parenchymatous keratitis of tertiary syphilis, (*b*) various varieties of syphilitic chorio-retinitis, (*c*) grave iritis accompanied by exudation in the anterior chamber or vitreous body, (*d*) gummata of the sclerotic, (*e*) syphilitic optic neuritis provoked by the development of a gummatous tumor in the course of the nerve or chiasm, (*f*) perhaps beginning ataxic, papillary atrophies and paralyses of the third pair rebellious to other medication.

These are the principal indications for mercurial injections; they may be considered as well established, but it is probable that others now under discussion may be determined upon. In this connection we see Prof. Fournier assert that injections of calomel do not seem to him preferable to other methods against secondary cutaneous syphilides, against mucous syphilides of the same period, adenopathies, nervous accidents, osseous manifestations, albuminuria, various cerebral and medullary localizations. Moreover, there is nothing gained with them in cases of papillary atrophy, tabes, and general paralysis. In opposition, Dr. Barthélemy maintains the usefulness of insoluble mercurial injections in obstinate secondary syphilides, in generalized anginas rebellious to other treatment, in grave neurasthenias of syphilitic origin. Dr. Portalier has had success with them in cerebral arterites, Thibierge in cranial hyperostoses with cephalalgia, Gaston in syphilitic albuminuria, Jullien in the majority of serious visceral syphiloses, etc. The realm of injection of insoluble mercurial compounds is then being extended little by little in all the grave, rebellious manifestations of syphilis.

This method ought, besides, to be employed when the digestive system can not support mercury, whatever the form administered, or when there is absolute need of abandoning it because other medication must be instituted at the same time.

There are other important questions which were raised by Jullien and Obadie. If there is one well-established fact, it is that we can never know, when a syphilis begins, what will be its future, whether benign or malignant; whether its manifestations will cease with secondary accidents of minimum importance, or go on after a variable lapse of time to most serious visceral lesions. This seems an indication to treat all cases of syphilis with prevision as to the probable outcome. If there is a moment in the evolution of the disease when it is necessary to strike a great blow in order to combat general infection of the organism, it is the instant when infection takes place, when the initial chancre appears, when ganglions are perceptible, when the virus is spread through the whole economy. We believe, then, that it is at least logical to make, from the time when the diagnosis is positive, a series of six or seven intramuscular injections of five to ten centigrammes each of calomel. Nevertheless, that indication can be considered now only as theory, for it lacks the confirmation of experience. It will be necessary to prove by many facts that injections of calomel are here what they are in other situations, the most active method, superior in efficacy to the gastric and cutaneous methods. That proof will, unhappily, not be furnished in a definite manner before long years have passed.

There is a real advantage, moreover, in making a series of injections in syphilitics who are about to be married. This indication is almost absolute (Jullien); the patient, in spite of the physician's interdiction, wishes to marry prematurely. It is to be considered also when the subject has been syphilitic less than five years, or has had recent accidents. In conclusion, let us recall that Dr. Barthélemy uses them in pregnancy when the syphilitic woman has already had miscarriages. He makes in these cases an injection of calomel once a month.

Contraindications to the Employment of Insoluble Mercurial Compounds.—This important point of syphilotherapy is not yet definitely fixed. According to the partisans of these injections, they should not be made (1) in those whose teeth and gums are in bad condition, (2) in those who, after administration of some mercurial preparation, have had, in spite of all precaution, an intense stomatitis, (3) in those who have varicose veins (Le Peleur), (4) in advanced cardiac disease (Barthélemy), (5) in diabetics, (6) in true Bright's disease (still it seems that they produce excellent effects in syphilitic albuminuria), (7) in those whose liver acts poorly, (8) in the debilitated, cachectic, worn-out old men (Jullien). Thibierge recommends them in the tuberculous; Barthélemy thinks the advanced disease a contraindication.

It appears that the method gives not the least result in tabes and general paralysis of syphilitic origin (Fournier, Barthélemy); it is therefore contraindicated in them. Finally, it is at least imprudent to employ it in persons obliged to live an active life, in particular female domestics.

The Question of Potassium Iodide.—When one rereads with care all the statements made regarding mercurial injections, he sees that all those who use them no longer employ potassium iodide, so to speak. Thence arise the following questions; May the iodide be administered at the same time that injections of insoluble mercurials are used? Is its employment in these conditions an aid to rapid cure, simply useless, or dangerous? All these questions, in spite of their importance, have been completely neglected in the recent discussion. It seems that in a majority of cases where injections are efficacious, iodide of potassium is practically useless. Ophthalmologists maintain that for certain ocular affections its simultaneous administration with mercury may be dangerous.

If it is true, as now asserted, that the iodide, far from favoring elimination of mercury, retards it, the drug should not be given when mercurial injections are accompanied by symptoms of intoxication. It is proper to ask if the unsuccess attending certain cases with injections alone, if the bizarre accidents pointed out by Fournier in certain cases of rapid disappearance of specific accidents when this method is employed are not in certain measure imputable to nonadministration simultaneously of the iodide.

Choice of the Insoluble Mercurial Used.—Among them there are now two which share the favor of French syphilographers. They are the gray oil and calomel.

The oil is injected in a mean dose of three and a half drops per injection. It seems to be much less painful than calomel. It requires a little more attention on the part of the physician, since it must be used in minute doses only, which are difficult to regulate exactly. An attempt is now being made to modify its composition so as to render it more useful. The chief objection to it is that it is less efficacious than calomel.

Calomel is injected according to the case, and to individual reaction, in doses varying from three to ten centigrammes per injection. The injections are repeated, taking into account the tolerance of the subject and the modifications undergone by the lesions, every eight, ten, or fifteen days. It is not possible to lay down fixed rules, which would be besides antimedical. From six to eight injections suffice ordinarily for one period of treatment. Calomel has the great inconvenience of being more painful than oleum cinereum, in causing much more severe inflammatory reaction, but its efficacy is far greater. Hence it seems the line of conduct is clearly traced.

In almost all grave cases preference is given to calomel, and the gray oil is used only when the gums are in a bad state, when there is reason to fear the development of severe stomatitis, and especially when injections of calomel provoke too great pain. It is well to begin them with one or two injections of calomel and terminate the series with injections of oleum cinereum.

Paris. L. Brocq.

Book Reviews.

Disorders of the Male Sexual Organs. By Eugene Fuller, M. D. Philadelphia: Lea Brothers & Co., 1895.

After reading Dr. Fuller's book on diseases of the seminal vesicles, with the many successful cases which he has treated by his process of "stripping," one can readily understand his enthusiasm upon the subject; and although we are inclined to think that his success has led him too far, in considering the vesicles as the paramount cause of the many disagreeable and protracted cases, with symptoms such as are described, as also in relegating to the background the prostate gland as at least a partial cause for these symptoms, yet he has evidently found many instances where he is justified in assuming the vesicles as the primary and most important lesion. Disregarding the fact, therefore, which we believe to be true, that many of the cases which we see (very similar in a clinical point of view to some of his cases) are due to and dependent upon prostatic lesions, and that many more are cases where both organs are involved, and that treatment must be directed toward both, yet Dr. Fuller has certainly done an admirable work in directing the attention of the profession more fully to the vesicles as a seat of disease, both in the nonspecific, gonorrhœal, and tubercular forms—a ground that has hitherto been very much neglected.

In his introductory chapter he describes some admirable dissections, accompanied by excellent plates taken from the dissections, with views of the prostate and seminal vesicles not usually met with in text-books on anatomy, and his work in this direction is to be highly commended.

In the chapter on pathology is presented the history of the various inflammatory conditions which are met with in the vesicles, and, among the author's twenty-two cases, we find that seven were tubercular, fourteen were gonorrhœal (acute and chronic), and one was simple—due primarily to venereal excesses, and intensified by surgical procedures to the deep urethra. The acute, tubercular condition is evidently rare, but not so the chronic, which is

not infrequently ingrafted upon a gonorrhœal condition, especially in strumous subjects.

An important practical point is brought forward, from the fact that tubercular epididymitis being often secondary to an infection of the vesicles, the latter can be easily overlooked, especially where the cord itself is not involved, and the patient be uselessly subjected to castration.

The new growths which have been observed in connection with the vesicles are echinococcus cysts, cancer (secondary to the prostate and bladder), and, very rarely, sarcoma. Calculi are also rare. Perivesicular inflammation is a frequent complication in any of the forms.

The symptoms referred to are inflammatory, functional, and neurotic, "more or less associated, and at times all three coexisting." Their severity does not correspond with the severity of the pathological changes, oftentimes marked subjective symptoms being present with a slight pathological process, or the reverse may be true.

The prostate gland is dismissed with these words: "It is usual for the prostate gland to become inflamed in this disease. It is difficult to decide whether such inflammation of the prostate should be classed as a coincident independent inflammation, or as a secondary one. It usually appears to be an independent inflammation due to the same cause which occasions the vesiculitis."

It does not apparently occur to the author that, with primary inflammation of the prostate and prostatic urethra, the ejaculatory ducts must of necessity become more or less involved, must lose their tonicity, giving rise in cases to an almost constant slight drainage of spermatic fluid, and that in time an extension of the inflammatory process would reach the vesicles.

A review of the various symptoms in detail which are mentioned, with their probable causes, would lead us too far. They are, however, very similar to those which we meet with when the prostate alone seems to be involved—i. e., where it is impossible to detect either tenderness or swelling in the vesicles, and which (symptoms) often subside under a course of massage of the prostate, provided it is administered intelligently, not too forcibly, and not directed toward neighboring organs which are not primarily involved, such as the vas deferens, when we are very apt to stir up an epididymitis, or at least a neuralgia of the testes, and in this way do the patient much harm. Dr. Fuller says it is usually possible with the ordinary and even well-trained finger to cover but about the lower third of the vesicle. This, however, would seem sufficient either forcibly to express the contents from the lower part of the vesicle (which we do not think should be the object of the treatment) or to stimulate contraction of the muscular layers of the organ, and in this manner empty as far as possible its diseased contents—in which manner we think the most good can be accomplished—not forgetting at the same time that it would be a physical impossibility for the finger to express the contents of the several extensions or blind sacs which open or empty into the upper part of the vesicle.

As we have said, the clinical results which are cited are most encouraging, and certainly sufficiently satisfactory to stimulate one to further investigation, and, though we can not agree with him in all of his deductions, Dr. Fuller's work is an admirable one and would well repay a reviewal.

John van der Poel.

Traitement de la Syphilis. Par Charles Mauriac, médecin de l'Hôpital Ricord (Hôpital du Midi). Paris: G. Masson, éditeur, 220 Boulevard Saint-Germain, 1896.

To the medical man who looks upon syphilis simply as a sequence of "chancre, secondaries and tertiaries," and whose whole conception of its treatment may be summed up in so many months of mercury, followed by so many months of iodide of potassium, this exhaustive treatise of Mauriac, embracing nearly nine hundred pages, exclusively devoted to the treatment and prophylaxis of syphilis, may be deemed a work of supererogation. To the specialist who is familiar with the "innumerable manifestations" of this protean disease, and the complexity and far-reaching character of its morbid processes, it would seem difficult to compress the proper consideration of its treatment within smaller compass. Syphilis is a disease which is as varied and widely different in its manifestations as are the personal peculiarities of the individuals producing them. It is impossible to formulate hard and fast rules of treatment which shall apply to all cases. Intelligent treatment demands an adaptation of means to the type or character of the morbid process as well as to the idiosyncrasies and peculiarities of the individual case. As the author states, "the treatment of syphilis does not consist alone in the administration of the remedies which experience has demonstrated to be most propitious to the cure of symptoms and specific lesions. It comprehends and embraces all the auxiliary indications which must be fulfilled in order to care for and cure a patient affected with syphilis."

It would be impossible within the limits of an ordinary notice to outline more than the general character and scope of this work. A mere *résume* of the contents, indicating the many points of view from which the various subdivisions of the subject have been considered, furnishes ample evidence of the thoroughness and completeness with which the work has been done.

In the introduction the author passes in review the numerous fluctuations which the therapeutic movement has undergone during the past four centuries, until the evolution of what may be termed the modern treatment of syphilis. The advances justify the hope that, with the progress made from day to day in this direction, there will be discovered infallible means not only to cure syphilis, but to prevent it by vaccination.

The body of the work is divided into three books. The first book is devoted to the general therapeutics of syphilis, under the following principal titles: General considerations upon the therapeutic effects of mercury and iodide of potassium; upon their curative and preventive action; mercurial treatment; the dermic method, mercurial frictions, fumigations, baths, plasters: the hypodermic method; the stomachal method, or by ingestion; hydrargyration; the iodide treatment and iodism; the auxiliary treatment of syphilis; non-specific medication; hygiene: thermo-mineral balneation; serum therapy; therapeutic strategy in the treatment of syphilis.

The second book considers the treatment of the divers manifestations of syphilis under three divisions. The first is devoted to primary syphilis, the second comprehends the treatment of secondary syphilis; cutaneous syphilides; syphilides of the mucous membranes and the other manifestations of this period. The third division embraces the treatment of cutaneous syphiloses, malignant precocious syphilis, gummata, dermic and hypodermic syphi-

loses of the genito-urinary organs; syphilis of the locomotor system; visceral syphilis, including syphilis of the nervous system; syphilis of the respiratory system, of the alimentary canal, the genito-urinary apparatus, the circulatory system, syphilis and diabetes.

The third book is divided into two parts: the treatment and prophylaxis of hereditary syphilis, and the general prophylaxis of syphilis. We can not follow the author in his careful and intelligent study of the numerous questions pertaining to the prophylaxis of syphilis. We are glad to find ourselves in accord with his position in regard to the unjust and one-sided character of the coercive measures employed for the suppression of syphilis. All repressive measures of which the woman alone is the victim, he characterizes as unjust, odious, and tyrannic. In championing the part of the woman, he takes the high moral ground—(1) that the responsibility for venereal diseases is the same for the man and the woman; (2) that coercive measures, such as may be deemed indispensable, should be applied equally to both. We have always contended that, as sex does not qualify crime, the woman is no more culpable than the man; further, that sanitary measures for the suppression of syphilis should not be directed solely against the woman, but, in order to be effective, should exercise the same surveillance over her no less responsible partner.

In concluding, we may congratulate M. Mauriac on the completion of the work upon which he has been engaged for so many years. The first volume, *Syphilis primitive et syphilis secondaire*, was issued in 1883; the second, *Syphilis tertiaire et syphilis héréditaire*, appeared in 1889. These three volumes, embracing over three thousand pages, form a monumental treatise on syphilis, which is an honor to the French school of syphilography and a credit to the talents and labors of the distinguished physician of the Midi Hospital. P. A. M.

Preliminary Programme of the American Association of Genito-Urinary Surgeons.—The tenth meeting of this association will take place at the Hotel Brighton, Atlantic City, N. J., on June 2 and 3, 1896. The following papers have been promised: (1) On Resection of the Kidney; (2) A Suggestion for a New Method of applying Sutures in the Operation of Nephorrhaphy, by Dr. Francis S. Watson, of Boston; (1) Operative Interference in Aggravated Instances of Seminal Vesiculitis; (2) Good Results following Urethral Resection, by Dr. Eugene Fuller, of New York; Post-conceptional Syphilis, by Dr. Abner Post, of Boston; Clinical and Pathological Notes on Syphilis, by Dr. John A. Fordyce, of New York; The Treatment of Rupture of the Urethra by Suture of the Canal, by Dr. A. T. Cabot, of Boston; Duration of Acute Gonorrhœa, by Dr. H. M. Christian, of Philadelphia; Prostatectomy; Improvements in the Technique of the Author's Operation, with Report of Cases and Presentation of Specimens, by Dr. Samuel Alexander, of New York; Treatment of Gonorrhœa, by Dr. W. Frank Glenn, of Nashville; (1) A New Remedy in Chronic Urethritis; (2) Two Cases of Urethral Chancre with Unusual Secondary Symptoms, by Dr. James P. Tuttle, of New York; (1) Report with Illustrations of an Interesting Case of Pseudo-Hermaphroditism; (2) Exhibition of a Syringe for Use in Infiltration Anæsthesia; (3) Note on the Correlation of Inflammations of the Urinary Tract with Lithæmia, Oxaluria, etc., by Dr. Bransford Lewis, of St. Louis; Outlines of Non-obstructive Ischuria, by Dr. Alexander W. Stein, of New York; Renal Tuberculosis, by Dr. F. Tilden Brown, of New York; Chronic Circumscribed Inflammation of the Corpora Cavernosa, by Dr. W. K. Otis, of New York.

JOURNAL OF
CUTANEOUS AND GENITO-URINARY
DISEASES.

Vol. XIV. JULY, 1896. No. 7.

Original Communications.

PRESIDENT'S ADDRESS BEFORE THE TENTH ANNUAL MEETING OF THE AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

By CLAUDIUS HENRY MASTIN, M. D., A. M., LL. D. (Univ. Pa.),
Mobile, Ala.

GENTLEMEN: Allow me, as your presiding officer, to congratulate you upon your safe arrival at this famed resort by the sea, and to welcome you to this the tenth annual session of our association.

At your Niagara meeting, a year ago, you did me the unexpected and unsolicited honor of an election to the presidency of this distinguished association—an association as unique in its purposes as it has proved to be important in its services to suffering humanity. It is now my pleasure no less than my duty to thank you for this generous manifestation of your esteem and your confidence. Unwilling to consume your valuable time with a formal address, one which would tend to crowd the scientific work of the association in the short time which has been allotted to the reading and discussing of papers prepared for the occasion, I desire simply to take a retrospective view of the causes which led to the organization of this association, and show the necessity which prompted its founders to create such a body.

The organization of a special association, one intended to be national in character, and having as its object the promotion of the study of genito-urinary and allied diseases, was at the time something entirely new, and I believe hitherto unknown. As would naturally be expected, its very novelty induced much adverse criticism; and the gen-

eral profession, unable to appreciate the necessity existing for such an association, or even to comprehend the intent of its founders, predicted an early demise after a brief and uneventful life. How far that prediction has been verified the work of the association at the close of its first decade will answer.

This association was organized primarily for the purpose of completing the several sections of the Congress of American Physicians and Surgeons, which congress was at that date in process of completion. Since the aim and intention of those who were engaged in forming that great National Confederation of Specialties in Medicine were to unite in one harmonious whole the leaders of medical and surgical thought in America, it was at once apparent that such an organization would be most incomplete and defective, unless there was added a separate and distinct section devoted to genito-urinary surgery. The necessity gave birth to the thought which has crystallized into the association here to-day assembled.

At that date there was not in existence any such special society as the one under consideration, and it was apparent that if such a section was to be added to the congress, the same must be organized. It was only of very recent years that genito-urinary diseases had been considered a distinct branch of surgery, and even then chairs devoted to them formed part of the curriculum of only a very few of the medical schools of America; the teaching of this branch being a part of the duty of the regular chairs of surgery. But the ground lay fallow, and ample material was at hand from which such a section as was needed could be created. In our large cities there were a number of gentlemen of distinguished reputations who devoted much of their time to the study and practice of this branch, but, with only a few exceptions, they were not considered or known as specialists in genito-urinary troubles. There existed in the public mind a false sentimentality, which cast a shadow of disrepute over a physician who was known to be especially skilled in the treatment of what was known as "private diseases."

In other departments the profession had been subdivided, and a number of special associations existed representative of almost every branch of medicine. To complete the congress an association devoted to genital surgery was a necessity, and must be organized.

The object of the congress was not to create specialties, but fully recognizing the importance of subdivisions of a wide field of scientific investigation and study, it had for its purpose the bringing together in one compact body such associations as had been formed for special study of special branches. Appreciating the fact that the special associations then existing were composed of men, and only such men,

who were of mark and reputation in that particular field of investigation, it was apparent that a confederation of the associations would bring together the representative leaders of the profession in all the departments. It was understood that each association zealously guarded its gates against the entrance of unworthy and unqualified persons, and as a consequence a congress composed of such membership must inevitably be of the most select and chosen material.

Its founders comprehended the fact that the time had come in the history of medical affairs in America when the special branches of the profession must be separately recognized; not that they be divided into distinct departments having no reliance one upon the other, but, each as an integral part of a great and undivided profession, they must be so associated as to stand:

> "Distinct as the billows,
> Yet one as the sea!"

This was the principle upon which was developed the Congress of American Physicians and Surgeons—the congress of which the Association of American Genito-Urinary Surgeons has come to be one of its most important and distinguished sections.

Early in the spring of 1886 at a consultation between three distinguished gentlemen—Drs. E. L. Keyes, Fessenden N. Otis, and Robert W. Taylor—the initiatory step was taken. A selection of representative genito-urinary surgeons of the United States having been determined upon, circular letters were issued inviting them to a meeting to be held in the city of New York on the 16th of October, 1886. At this preliminary conference Dr. Keyes was chosen as temporary chairman and Dr. Taylor as secretary; a roll of membership was selected, and the usual steps of organization were taken. A committee was appointed to draft a constitution and by-laws, which was discussed at a subsequent meeting in New York on the 6th of November, 1886, and again on the 4th of February, 1887, and the 29th of March following. The details having been arranged, the association was declared to be fully organized, and the first meeting for scientific work appointed at Lakewood, N. J. At this meeting a limited number assembled at the Laurel House, on the 17th of May, 1887. The scientific work was all that could have been expected at the first meeting, and the association having selected a delegate and alternate to represent it at the approaching session of the Executive Committee of the congress to be held in the city of Philadelphia on the 5th of October proximo, adjourned, to meet conjointly with the congress at its first session in Washington in 1888. At the meeting of the Executive

Committee the delegate from the Genito-Urinary Association was selected secretary of the committee, and thus it became a prime factor in the organization of the congress. It was created to fill a vacuum; it became one of the foundation stones of the temple. Its first conjoint meeting with the congress was at the September session of 1888. Since that date to the present its annual sessions, together with its conjoint meetings with the other associations, have been well attended, and not barren of results.

Its past history gives promise of more important work in the future; and composed as it is of a class of representative men in this specialty, we are safe in predicting that under their guidance the department of genito-urinary surgery in America will in the near future be fully recognized as one of the most important of the sections of medicine. The classic papers of its members at the last congress attest the material of which the association is composed, and show that the work being done is fully abreast of all other special departments. In the past ten years great advances have been made in the field of genito-urinary disease. The various organs which are comprised in its domain have been studied and thoroughly investigated. Our knowledge of their pathology and the therapeutics required for their treatment have each been systematized. Our instruments for investigation have been improved, and new ones have been invented; the technique of our operations has been simplified and perfected. The kidneys, the bladder, together with the organs of generation, have been opened up and illuminated; the hidden recesses of the entire system have been exposed to the eye, so that no longer are we groping in the dark, but, aided by all the improvements of modern research, our diagnosis of hitherto obscure troubles has been cleared of doubt. Some of the brightest minds of past ages have done much in the department of genito-urinary diseases, and through their investigations it has been recognized as of great importance. The immortal John Hunter understood its bearing upon scientific medicine, and indelibly impressed his name upon the very keystone of modern pathology—the hard chancre; his researches in this line blazed out the pathway to our present knowledge of syphilis. As we look back and call to mind the workers in this special field, we find that a large number of the most distinguished men of the eighteenth and nineteenth centuries have devoted themselves to the study and treatment of genital diseases. Such men as Wiseman, Cheselden, Civiale, Heurteloup, Leroy, Ricord, Cullerier, Sigmund, Zeissl, Maisonneuve, Guyon, Reliquet, Reybard, Dittel, and Trelat, besides numberless others in the Old World, have given it a high place in the department of medicine. In America, and in very recent years,

the names of Bigelow, Otis, Keyes, Bumstead, Van Buren, Taylor, Morrow, Chismore, and Bryson, with a host of others which it would be invidious to mention, form a bright constellation in the firmament of the profession; they mark an epoch in medicine, and give tone and dignity to a specialty—great men, whose mighty footsteps will echo down the corridors of time.

In conclusion, gentlemen, if it will not be assuming too much, I would like to suggest that, as our association is now, at the end of its tenth year, fully established, we may with safety to its reputation extend the constitutional limit of its membership. We assume that, in the widespread territory of our country, extending as it does in one direction from the Atlantic to the Pacific Oceans, and in the other from the Great Lakes of the North to the Mexican Sea in the South, embracing millions of square miles, and populated by an intelligent and progressive people, there are numbers of young surgeons, active, energetic, and ambitious of distinction, who, appreciating the importance of our specialty, will seek admittance into our ranks. We comprehend the fact that the more there be of active workers in the field, the greater will be the development of the treasure which is to be produced, and that we arrogate too much to ourselves when we deny them the right to fellowship. Just here I desire to say, I wish it distinctly understood that I do not advocate opening our doors to any or all who may seek to enter therein; but I would urge, when worthy and qualified men are found who desire to ally themselves with us, that due consideration be given their claims, without reference to a numerical clause in the constitution. Since the present membership has elevated the association to its high place of distinction, it is our duty to ourselves, as well as to the congress at whose gates we stand as a sentinel, that we protect the purity of the association. We should make genuine ability and scientific work the prerequisites for admission, and continued scientific activity the recognized duty of membership. Then let our limits be marked by ability rather than circumscribed by numbers.

Another point which I think worthy of your consideration is, we should not confine our places of meeting to a limited geographical area. We must remember that ours is a national association, whose membership is widespread; and I think that, in view of the great distance at which some of our members reside, the two alternate sessions, from the one in which we meet with the congress at the capital of the country, should be arranged to meet at some center in the West or the South, as well as at the East or the North. Such a liberal distribution of our places of meeting will broaden our influence and

strengthen our friendships. It will certainly lessen the distance of travel for many of us, and insure more uniform attendance.

During the ten years which are now drawing to a close since we organized, our sessions have been replete with many very valuable papers relating to genito-urinary diseases. They have been published in various medical journals of the country, and, as a consequence, are not of easy access at any and all times. While I would be opposed to any action of the society restricting our members from the right to publish their productions whenever and wherever they may desire, I would advocate that these papers be collated and a yearly volume of our transactions be published. Such publications are common and almost universal with the other special associations, and are valuable additions of reference to our professional libraries. They become the ready means of quick and easy research, and in the ages to come will be important as archives of the association, showing the advance of the specialty which they represent.

In this connection I might suggest that a suitable certificate of membership be prepared, with an appropriate seal, and that the members be furnished with certificates bearing the impress of the same. We have set up for ourselves a high standard, and the day is not far distant when it will be a proud distinction to be known as a member of the Association of American Genito-Urinary Surgeons.

THE DIAGNOSIS OF LIQUID OR SEMILIQUID FORMATIONS IN THE INGUINO-SCROTAL REGION.*

BY THOMAS H. MANLEY, M. D.,
New York.

IT has been a matter of common observation of late years that the art of diagnosis of disease is far in advance of treatment; that precision and accuracy in the detection or recognition of various maladies have attained to their height of perfection; and hence we must infer that little remains to be done in this direction.

This, however, though generally true, has many exceptions, as daily events clearly demonstrate. Much of this mistaken opinion has arisen in consequence of the dominant position at the present time occupied by the microscope in morphological studies.

* Read before the Genito-Urinary Section, New York Academy of Medicine, April 14, 1896.

But the many subtle and mysterious phases of disordered nutrition, yielding to no definite law, only too often elude every rule of diagnosis, defying and confounding the most expert histologists and diagnosticians.

While an opportunity offers I wish to avail myself of it to utter a warning against the common current practice of being influenced too far in surgical practice by the revelations of the microscope. A general tendency in this direction at the present time is tending to the performance of too many operations with such a needless sacrifice of organ, structure, or life itself, as to be scarcely less than a wanton mutilation.

The contents of the scrotal bag, and the canal leading to it, have been chosen on the present occasion for the consideration of some of the pathological lesions encountered therein, because in no other region of the body, equally exposed, are so many errors liable to be committed in diagnoses.

Among other things, I will direct your notice to that infirmity so generally known as *hydrocele*.

It certainly is most extraordinary that some writers and teachers of distinction should still persist in declaring that it is an infirmity easy of recognition. Thus, one says, "The diagnosis of hydrocele is usually easy" (*Venereal Diseases*, p. 475. Robert Taylor, M. D.).

"Cases of hydrocele which can not be readily recognized on examination must be very rare," says Reclus (*Malad. Ven.*, p. 449. Monod et Reclus). My own experience with something more than fifty cases of neoplastic and adventitious formations within the scrotum within the past ten years has convinced me decidedly to the contrary.

The correct recognition of these hygromata is a matter of much greater importance than is generally supposed.

The confounding of a hydrocele with a cystocele leads to awkward surgery, while precision and accuracy in diagnosis point the way to a simple, safe, and radical therapy. For example, in a serous cyst of extravaginal growth, decortication and avulsion promise a permanent cure. In more than one fourth of the patients coming to me for treatment for what they supposed was hydrocele, cystic tumors were found and removed. One had been tapped four times, the patient having been told that he would never recover from his infirmity, while, as a matter of fact, the vaginal tunic was entirely free.

Symptomatology.—The subjective symptoms will throw much light on the probable character of scrotal cystic tumors.

The presence or absence of a marked cachexia and of vesical or intestinal disturbance are to be noted.

Marked impairment of the sexual power is suggestive of a fluid formation in the vicinity of the spermatic cord or testicle. Persistent, lancinating pain without evidence of febrile disturbance leads one to suspect malignant disease. Pain of a severe form is commonly associated with tubercular testis, but it is also attended with hectic and other signs which can be scarcely misinterpreted.

All tumor formations, except, possibly, malignant and syphilitic sarcoceles, seem to suffer a marked diminution in volume in the recumbent position. This is notably the case in hernia, and is quite general in hydrocele and funicular cysts.

We are often led to strongly suspect the presence of a genuine hydrocele rather by the absence of any positive subjective symptoms. It is usually only when a hydrocele or serous cyst has attained to a considerable volume that a person becomes conscious of its presence.

Even pain in the back may be wanting if a suspensory bandage is worn.

In these brief notes the diagnostic features of hydrocele and serocystic disease only can be considered, the presence of which are manifested in their order of utility by—

1. *Increase in volume of scrotum.*
2. *Palpation.*
3. *Fluctuation.*
4. *Transparency.*
5. *Aspiration.*
6. *Open incision.*

These to-day constitute our main reliance, although some of them are misleading and are inadequate aids in the establishment of a definite diagnosis.

Enlargement of the Scrotum.—It goes without saying that mere increase in volume of the scrotum in itself can be disregarded altogether as a sign of hydrocele when taken alone, though the manner in which the enlargement develops will throw some light on the probable character of the swelling.

For example, if the patient states that the fullness came on suddenly after a strain, appearing first in the groin, we may suspect hernia.

Nevertheless, it is the experience of every one that too many come to us with complaints of "strains" who are suffering from specific buboes or sarcoceles. The growth of a typical hydrocele is always from the base of the scrotum upward.

Palpation.—Digital manipulation, skillfully applied, is of great value here. In some of those "strain" cases we recognize at once, by

the surface temperature, that an acute process is going on in the underlying parts; for in hydrocele there is no elevation of temperature. By it we readily determine consistence, form, relations, and outline. Whether tenderness is present or not is of great importance, as well as the position of the testis.

In medium-sized, large, or tense hydrocele the position of the testis can not be defined. In quite a few it can not be felt at all. It seems to rise from its stalk in the gubernaculum and float in the middle of the fluid; or, if pressed against the vaginal tunic, an induration and thickening of the overlying investments render its detection quite impossible. On the contrary, when we find the testicle knoblike, isolated, and projected against any part of the wall of the scrotum—either at its base, summit, or either sides—we may be quite certain that the tunica vaginalis is not involved; and therefore when this anatomical arrangement is discovered we will have almost invariably either a hernia, a scrotal cyst, or a neoplasm of some description advancing downward, either from the epididymis or the funicular process.

Fluctuation.—Fluctuation is of more value, although when an investing capsule or limiting membrane of an organ is put to a great strain by distending fluids, its whole outline may offer such resistance and be of such a strong hardness as to suppress it.

An instance illustrating this fact came under my own observation three years ago in an old man. An eminent clinician, who had examined him the day before I saw him, pronounced his affliction as cancer of the liver. Although he was somewhat ieteric, there were some features in the case which led me to suspect that the vast tumor, which greatly distended the right side of the abdomen, was of renal origin. To settle the doubt a fine aspirating needle was sent in, and one ounce of fluid was withdrawn, which on examination proved to be pure urine. He had a hydronephrosis, which that same day was drained away, and through a nephrectomy the remaining shell of renal tissue was removed, when all jaundice and other symptoms of distress disappeared.

We may, too, find a sense of fluctuation at times in formations which are not entirely fluid, as in lipomata and certain types of sarcocele. It undoubtedly is a sign of great value in these cases, though it is well to avoid error by not attaching too much importance to it under all circumstances.

Translucency or Transparency.—Tumors of the scrotum which readily transmit light are generally set down as hydrocele without any further comment, and those in which their transparency is absent

are always looked upon as of a doubtful character. This probably has led Reeins to declare that "cases of hydrocele which can not be readily recognized on examination must be rare." If he means by this all descriptions of fluids, cystic and noncystic formations in the scrotum, he undoubtedly is correct, but, on the contrary, if this statement applies to hydroceles in the vaginal tunic, he certainly is in error.

When fluid is present in small quantities, or when the perivaginal fascia is greatly thickened by chronic inflammation, or when the deposits have undergone pigmentation, this sign may be entirely absent. Under this head Percival Pott remarked that "the transparency of a tumor is the most fallible and uncertain sign belonging to it, and is a circumstance which does not depend on the quality, consistence, or color of the fluid constituting the disease so much as the uncertain thickness of the bag and of the common membrane of the scrotum. If they are thin, the fluid is so quickly formed as not to give the tunica vaginalis time to thicken much; the rays of light may be seen to pass through the tumor, but this is accidental and is not to be depended upon. Whoever would be acquainted with the disease must learn to distinguish it by other and more reliable means, or he will be apt to fall into very disgraceful and pernicious blunders."

Of the above remarks Curling observes that "the value of transpareney has been underrated," though he very properly adds that absence of transpareney is no proof that a hydrocele does not exist. It is evident that among negroes and mulattoes this sign has no value. It may be observed, too, that in the enormous scrotal distention of general dropsy the scrotum is always transparent to reflected light. In a recent case of sudden distention of the tunica vaginalis by a large serous effusion, following a strangulation of a small coil of the intestine, which advanced downward but a short distance outside of the external ring, I was able to perceive perfect transparency. In cystic or multiloculated hydrocele it is a sign of no value whatever. By itself, then, fluctuation must be conceded to be of doubtful utility, delusive and uncertain. The electric illuminator devised by Dr. W. K. Otis, of this city, serves a valuable purpose in detecting liquid accumulations in external parts, and may be utilized here with great advantage.

With Röntgen's late wonderful discovery of the applicability of photography to the living body by the aid of cathodal rays, it is highly probable that with the further development of this truly remarkable means of piercing opaque substances by rays of light we may be enabled by its application to study with precision tumors and effusions within the scrotum and other regions. Sidney Rowland has by this

means photographed the renal vessels (*British Medical Journal*, February 27, 1896), although, so far it would seem to be limited largely in its sphere of usefulness to lesions of the skeleton and the localizing of foreign opaque or solid substances within the body. According to the latest reports from Paris, Lannelongue, Berthélemy, and Ouidin have been enabled to diagnosticate with the Röntgen rays peripheral and central necrosis of the carpal phalanges, and, moreover, in one case of a boy recognize incipient periosteal tuberculosis (*Gazette hebdomadaire*, 2 février 1896).

If, in the evolution of this new source of scientific light, its application is generally extended, and its present rather crude results are rendered clearer and more definite, possibly, after all, illumination and photography will enable us to realize as much from this source as it is possible from any other without a mutilation of tissue.

Puncture or Aspiration.—This is a most helpful aid, and is the most decided as an objective sign. It at once in recent uncomplicated cases will decide the presence or absence of fluids; furthermore, by a careful analysis of the withdrawn material we may be enabled to determine its precise character and source.

It is an expedient, however, which should never be resorted to unless we have eliminated the possibility of hernia, nor unless other diagnostic resources have failed, and never without the most thorough sterilization of the point of puncture and the needle.

Like every other resource it has its limitation—hence, its revelations are not to be always relied on. This was lately illustrated in a case of suspected hydrocele in a patient who came under my observation.

My patient was a middle-aged man, who was suffering from pulmonary tuberculosis, and gave a history of having an orchitis subsequent to a gonorrhœa which he had contracted before. On examination of the swelling, which involved the right testis, it seemed to me to present features of hydrocele rather than an orchitis succeeding either clap or tuberculosis.

I passed an aspirating needle in and withdrew a drachm of serous fluid, when no more would come away. Then a free incision was made, when the tunica vaginalis was found stuffed with a semiorganized myxomatous substance in various independent locules.

This was a most excellent case to refute the absurd claims of those who favor injections for the cure of hydrocele and reject the incision. In my essay before the Surgical Section on Treatment of Hydrocele, etc., Dr. F. B. Curtis, presiding officer, alleged that we could separately inject each locule, but it would be interesting to know how one can see the independent compartments through the dense scrotum.

The fluid of hydrocele has many of the characters of plasma. It coagulates by heat, and on the addition of acids deposits a thick, flocculent material of a fibrogenous consistence. This is something which would appear to demonstrate its inflammatory origin, for this never occurs in simple aqueous transudations. Under the microscope we find in it fragments of endothelia, a granular substance, cholesterin crystals, and spermatozoa. These two latter are not constant. In my own cases the generative elements were wanting, except in two young men.

The Open Incision.—Modern science and the recent achievements in the art of surgery now permit us to add another aid in the diagnosis of scrotal tumors, more positive and exact in results than all the others combined. Certainly, discrimination must be made in its employment, and every safeguard utilized which will obviate or remove all possibility of damage from hæmorrhage or infection. This done, by the sense of sight and touch through the free *open incision*, the whole field can be quickly and thoroughly explored, and, what is more, in many the simple opening made for diagnostic purposes will effect a cure.

Of late years in abdominal surgery operators have come to regard an exploratory incision as justifiable as a diagnostic expedient in all those cases not distinguishable by other means. Arbuthnot Lane, of Guy's Hospital in London, and Lucas-Championnière, of Paris, recommend it in doubtful fractures. Nevertheless, it should not be lightly undertaken until other means of diagnosis have failed, and then only after a most thorough preparation of the patient, and when everything is in readiness proceed rapidly and complete whatever operation may be necessary. In diabetic or in debilitated old men it should be remembered that the vitality of the scrotum is feeble. A sloughing sore or serious constitutional trouble may follow a trivial incision through it.

The Diagnosis of Complicated Hydrocele.—Hydroceles, or aqueous accumulations, are occasional concomitants of various types of hernia. Their anatomical bases and physical characters widely vary, but in one respect they are all alike.

Accumulations of fluids within the scrotum, though generally consecutive, at least in the adult, *per se* give rise to no inconvenience, unless they attain considerable volume.

It has long been my conviction that in those cases of large and sudden effusions into the sac, in strangulated enterocele, its simple evacuation might, by the removal of hydrostatic pressure, lead to a reduction of the tumefaction, compression, bending, or torsion of the

intestine, and favor relaxation of spasm and spontaneous return; but in many of these cases the tension of the scrotum is so great that we can not determine by palpation either the presence or extent of the extrusion.

In this class of cases, again, we might utilize the aseptic incision, for the dual purpose of diagnosis and relief. There are many circumstances which sometimes render a kelotomy a hazardous procedure. Moreover, there are cases of acute intravaginal dropsy so compressing the testis as to provoke symptoms not entirely unlike strangulation of the bowel. In those acute cases presenting ambiguous features the free incision will prove a most useful and decisive agency in diagnosis.

In chronic, irreducible hernia we will sometimes encounter cases which have suddenly undergone a considerable increase in volume. This usually occurs after an injury to the scrotum or violent strain. In either event the scrotum may be so distended as to quite obliterate the penis, and descend in a massive pouch toward the knee. Scarpa has reported such an instance in which, in twenty-four hours, nearly a gallon of fluid accumulated. Incision not only brought relief, but likewise opened the way for the detection of a small, extruded coil of intestine, which at the same time was returned, and the young man cured of his infirmity (Wishart, *Diseases of the Testis*, quotation from Scarpa).

In all cases, therefore, in which a distended sac of fluid is present in hernia, giving rise to inconvenience or suffering, when there are no contraindicating conditions present, we should not hesitate to make an opening and inspect the invaded territory.

When cystic disease or hydrocele complicates a non reducible hernia in children, the incision immediately clears the field of all uncertainty in diagnosis, and in itself may greatly favor spontaneous cure.

Victor Bougn, in a recent contribution on this subject, emphasizes the advantage of the free incision as a precise means of diagnosis in all varieties of cystic diseases of the scrotum (*De l'extirpation de kystes de l'epididyme; avantage et résultats immédiats.* Thèse de la Faculté de Paris, 1896. *Gazette hebdomadaire*, 14 avril 1896).

The absolute diagnosis of *extravaginal cysts* of the epididymis, rising from its visceral base or the elements of the cord, determines rational, definite treatment.

About one third of those cases sent to me for treatment of supposed hydrocele have been proved, on incision to be purely neoplastic or adventitious formations. They present practically many of the gen-

eral features of hydrocele, although their mode of development and the position of the testis are different.

In large hydroceles the testis can not be detected on palpation, while in serotal cysts it will always be found isolated, and occupying an independent position.

Some of these hygromata lodged in the inguinal canal between the rings or just outside of it are more or less reducible to pressure, and, moreover, in many we will have a history of spontaneous diminution in volume after a night's rest. In some of them of an oblong contour, and possibly continuous with the peritoneal cavity, on coughing or straining we will have an impulse quite similar to that so obvious in visceral escape.

When of large volume, not only is the serotum greatly distended, but the inguinal canal likewise, in this manner producing an appearance not altogether unlike an old incarcerated hernia.

Indeed, not a few of those watery tumors present some of the anatomical elements of hernia. For example, when a hernial sac has been emptied by taxis, the contained viscera having been firmly trussed up by pressure and its neck obliterated, its serous surface may go on secreting, and thus widely expand the peritoneal pouch. Some of them are evidently protrusions of the parietal peritoneum which, after they fill, are continuous with its cavity.

In some, too, we will have cystic degeneration of the adenomatous elements of a small extruded fringe of omentum, producing a genuine cystic hernia. Finally, the cystoid mass may consist of a part of the bladder wall—vesical ectopia. Lardy recently cites three such cases, two in males and one in a female (*Trois cas de cystocèle, au cours d'herniotomies*, par Ed. Lardy. *Revue de chirurgie*, 10 février 1896).

In these cases the cystocele was no larger than the first joint of the thumb. Lucas-Championnière, Monod, Reverdin, Guterbeck, and others have recorded similar cases of late. Uncomplicated neoplastic cysts are most commonly formed in the serotum, developing within the loose myxomatous tissue of the spermatic cord, or from the so-called "hydatids of Giraldes" in the head of the epididymis, in the course of growth advancing in different directions.

The constitutional symptoms in simple, uncomplicated inguino-serotal cysts, as in hydrocele, are practically *nil*. The history of infection is wanting; there is no febrile disturbance; neither the hectic of phthisis nor the pain of malignancy is apparent.

The fluid contents of these heterogeneous masses will shed some light on their pathological composition. The fluid withdrawn contains fewer epithelial elements, is of a lower specific gravity than that of

hydrocele. It is of a watery, colorless appearance, and always of an alkaline reaction. In only a small proportion, in my own cases of cysts—about a third—a few more or less disintegrated spermatozooids were found.

These autogenous cysts are not difficult of recognition in recent uncomplicated cases, but when of great volume, possibly complicated by chronic hydrocele or hernia, they may be extremely difficult of detection.

In the simpler variety we may use the exploratory needle, and analyze the contents, aspirated; though it is always well to remember the possibility of doing harm by a puncture, by piercing an intestine, blood-vessel, or the testis.

When one is in doubt, and the patient has decided to submit to an operation for radical cure, then the only safe and positive diagnostic resort we have at our command is the *free incision*. This lays everything bare before the eyes, leaving no possible room for doubt; and at one and the same time permits immediate treatment to follow diagnosis.

By proper attention to thorough asepsis and hæmostasis all danger is obviated by the incision. But, perhaps, one may allege, Of what consequence is precise diagnosis when practically the same line of treatment is appropriate for all the cystic masses?

If evacuation and injection will cure simple hydrocele, may they not also do the same for cysts? Probably in some cases, but in chronic serous cysts, wherever located, evacuation and the injection treatment are out of date, antiquated, and unsurgical. The only rational treatment for these cystic formations, wherever located, when it is practicable, is complete dislodgment by a clean dissection; something not likely to be undertaken without a definite knowledge of the condition present. Accurate diagnosis, then, is the key to radical and permanent cure in all these cases.

A CASE OF FOLLICULITIS DECALVANS.

BY GEORGE THOMAS JACKSON, M. D.,

Professor of Dermatology in the Woman's Medical College of the New York Infirmary, and in the Medical Department of the University of Vermont.

THIS disease is so rare that cases of it should be reported whenever met with, as it is only by such observation and study that we can formulate our knowledge of a rare disease.

The case now reported is that of Miss T. She is thirty-five years old. Her health is poor. She is nervous and worried over family



FIG. 1.

matters. Her appearance shows that she is harassed, as she is very thin and her face is drawn. Her hair turned gray prematurely. She suffers with intense headache. The disease began six years ago on the vertex, the location shown in Fig. 1. Since then new patches have formed from time to time, especially since she was injured in a rail-

road accident about one year ago. None of the old patches have got well. On the contrary, they tend to spread slowly into the surrounding parts. There are now some ten patches scattered over the scalp. They are irregular in shape, cicatrized in their centers, and push out into the surrounding parts, so that the full extent of the ravages of the disease can be seen only by raising the hair about them. They vary in size from a marrowfat pea up to a patch two inches or more in diameter. The patches seem to begin by the appearance of a



Fig. 2.

small red spot with stumps of hair in it. This slowly invades the surrounding parts, the oldest part becomes crusted, and when the crust falls the scalp is found to be cicatrized and reddened. The disease is attended by no discomfort to the patient. The appearance of the patches is beautifully shown by the accompanying illustrations (Figs. 1 and 2).

Ever since the beginning of the disease the patient has been treated by various physicians, but without any benefit.

It seems to me that no other diagnosis than that of folliculitis

decalvans can be made in this case. Trichophytosis might be thought of. Against this we have the age of the patient, the absence of the fungus in the hair, the irregular shape of the patches, and the manner of their spread. Alopecia areata is another possible diagnosis, and one that would have been made before we knew of the existence of follieulitis decalvans. It differs from alopecia areata in the chronicity of the patches, in the redness of the scalp, in the crusting that is seen in one part of their course, in the irregular shape of the patches, in their peculiar invasion of the surrounding parts, and in the cicatrization of the center of the patches.

The course of the disease is evidently inflammatory, and it spreads as if from local infection. We are absolutely ignorant as to the cause of this peculiar disease. Thus far the cases have been refractory to treatment. In the present case I have advised epilation about the patches, washing of the scalp with soap and water, and the application of the ointment of the ammoniate of mercury to some of the patches, and to others a preparation of iodine and goose grease. This latter preparation has been used with success in the treatment of the parasitic diseases of the scalp in Prof. Fox's service in the Vanderbilt clinic. As goose grease is reputed to have great penetrative properties, it occurred to me that it should be an excellent vehicle for the introduction of iodine in trichophytosis capitis. I have a half drachm to a drachm of the crystals of iodine dissolved in an ounce of goose grease, and apply this by means of a stiff painter's brush. It has done good service in ringworm and favus, though it does not seem to be as efficient as is chrysarobin.

BULLOUS QUININE DERMATITIS.

BY JAMES C. JOHNSTON, A. B., M. D.,

Dermatologist to Lying-in Hospital; Assistant Physician, Department for Skin and Venereal Diseases, New York Hospital, etc.

A REVIEW of the literature of drug eruptions classified in the *Surgeon-General's Catalogue* and *Index Medicus* (1887–'96) reveals numbers of cases of quinine dermatitis of the scarlatiniform, urticarial, and even of the vesicular form. There are very few reports of cases of the bullous type. Morrow, in his *Drug Eruptions* (page 109), mentions two instances published by Bergeron and Prost,*

* *Annales d'hygiène pub. et de méd. lég.*, lxviii, p. 5.

and by Fowler.* Colcott Fox makes no addition to them in his annotation of the work for the Sydenham Society publication of 1893. Besides these, two others only have rewarded my search—Elliot † and Haralamb,‡ of Bucharest, reporting them. Astley Leggatt's # case, mentioned by Haralamb, seems to belong in the scheme of classification more to the vesicular form. In fact, he so calls it. (I do not mean to convey the impression that these are the only cases in literature; they are all I have been able to find.)

The patient who is the subject of this report has had two attacks of quinine dermatitis, presenting himself in them at the New York Hospital in the summers of 1894 and 1895. His first outbreak, occasioned by the ingestion of two two-grain quinine pills, became in its later stages vesicular, but is interesting only as showing his idiosyncrasy, and enabling us to make a diagnosis promptly on his second appearance.

He is of German extraction, thirty-seven years of age, and a waiter by profession. His attack was brought on, as I learned later, by two doses of fifteen drops each of compound tincture of cinchona in a tonic mixture. Fortunately for himself, recognizing the premonitory itching of genitals, face, and ears, and suspecting the cause from his previous experience, he stopped his medicine at the second dose. Two days later, August 14, 1895, he came to the hospital complaining of an intolerable pruritus. Vesiculation was beginning on his face, particularly on the forehead and ears. The whole surface of the body was covered to all intents with a scarlatiniform dermatitis, the palms and soles somewhat less red than the remainder of the cutaneous surface. The mucous membranes were not then or afterward affected. Two days later, I saw him at his home, since he was unable to move hand or foot to help himself.

Vesiculation had gone on to bullous formation. The vesicles on face and ears had burst and serum was trickling down his face in droplets like sweat. About the mouth they had attained the size of a pea and the body surface was generally in better condition, though dotted here and there with irregular groups of vesicles. The genitals were still much affected, but the principal and most interesting change was in the palms and soles. On the feet bullæ were present on the heel, on the ball of the foot, one lesion over each metatarso-phalangeal articulation, and on the balls of the toes themselves. The dorsum was

* *N. Y. Med. Times*, May, 1883, p. 33.

† Journal of Cutaneous and Genito-Urinary Diseases, 1888, vol. vi, p. 326.

‡ *Annales de derm. et de syph.*, t. vi, No. 12, p. 1148.

Lancet, October 4, 1890, p. 720.

covered with small vesicles. On the palms the bullæ occupied both eminences and raised the skin over each phalanx of every finger and the articulations with the metacarpals. The instep and center of the palm were free. About half a pint of serum was taken from the larger lesions. On August 19th, while the body was almost free and the face much improved, the feet and hands were worse. The whole horny covering of the palms depended in the shape of half-filled bags of fluid, the skin of the fingers being raised from the tip to the last articulation. On the soles the bullæ had coalesced and were even larger. They had developed also on the backs of both fingers and toes. Again they were emptied. Exudation continued for some days, but repair began shortly and was completed in five or six weeks. The tenderness of the surfaces denuded of horny covering was for some time exquisite and delayed recovery. The use of the feet was regained much sooner than that of the hands. The bullæ were entirely intra-epidermic, for there was no opening anywhere of the vessels of the corium. The treatment adopted in the early stages was the use of astringent lotions of calamine and zinc and black wash; later, when the bullæ disappeared, diachylon and zinc ointments.

The chief feature of interest in the case, aside from its rarity, is the enormous disproportion between the violence of the cutaneous outbreak and the amount of the drug ingested, and in the continued increase in severity long after all traces of the drug must have been eliminated, a fact noted in other connections—e. g., iodic eruptions The palms and soles have been the sites of predilection in all the cases collected, but the bullæ have appeared also about the mouth and genitals, though hardly so extensive as in my patient. Bergeron and Prost state that there was a concomitant bronchitis. They quote also from Panas that bullous eruptions from quinine are not uncommon in the Levant, where large doses are given. Haralamb likens the appearance of the denuded surfaces to erosive syphilides, which would seem to indicate some uncovering of the corium.

115 WEST EIGHTY-FOURTH STREET.

Society Transactions.

AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

Tenth Annual Meeting, held at Atlantic City, N. J., June 2 and 3, 1896.

First Day, Tuesday, June 2d.

Dr. Claudius H. Mastin, *President, in the Chair.*

Address by the President*—Dr. Mastin, of Mobile, Ala.

Five Cases of Rupture of the Urethra treated by External Urethrotomy and Suture.—Dr. A. T. Cabot, of Boston, read a paper on the subject. He stated that the intractable nature of traumatic stricture of the urethra was so well known that no apology was required for a report of some cases in which an attempt was made by immediate suture of the ruptured urethra to furnish accurate coaptation of the divided ends of the canal, and by promoting rapid and smooth healing of the mucous membrane to avoid the formation of stricture. Hitherto, the latter has been regarded as an inevitable consequence of a urethral rupture, and while in the fortunate cases of moderate severity the regular passage of a sound may keep the urethra permeable, neglect of this precaution may be expected to result in a rapid closure of the stricture. In other cases of greater severity the stricture showed a constant tendency to contract in spite of every effort to keep it open, and repeated operations are required to avert the serious consequence of a complete closure.

Dr. Cabot then reported five cases of traumatic rupture of the urethra which were treated by immediate external urethrotomy and suture. The history of the first case was as follows: J. C., aged eighteen; was admitted to the hospital on August 28, 1891. Twenty-six hours previous to his admission he fell astride of a barrel, injuring his urethra; since that time he had passed no water and all attempts to introduce a catheter had failed. Under ether, perineal section was immediately done. The bulbous portion of the urethra was so much crushed as to be divided across two thirds of its extent, and only a narrow strip of the roof of the canal remained intact. This rent in the urethra was closed by four catgut stitches, so taken as to include the muscular and cavernous tissue surrounding the urethra, but not encroaching upon the mucous membrane. When these were tied the canal was so far restored that a catheter slipped in with perfect ease. It was fastened in place and the outer part of the wound was left open, so that in the case of any leakage the urine should not be shut up within the tissues. Recovery was uneventful. The catheter was removed upon the tenth day, and the patient left the hospital well at the end of twenty days. For two years afterward this man had intermittent treatment with sounds and bougies, in accordance with

* See page 249.

advice given him at the hospital. He was last seen on March 10, 1896, when he reported that he had had no instruments passed for three years. His urine was clear and passed in a good stream. Sounds Nos. 26 and 28 were introduced without meeting any resistance and caused no bleeding.

Four other similar cases were reported by Dr. Cabot. In all the cases the immediate result of the operation was good. In three of them the opportunity was given for examination some years after any dilating instrument had been used. In cases one and five no stricture was found, and instruments as large as or even larger than those used immediately after the operation slipped past the point of rupture with perfect ease. In one case, while no interference with urination was noticed, a narrowing of the urethra was found. This narrow point, however, was not of a hard, cicatricial nature, but was so soft and yielding that without the least exercise of force it was rapidly dilated to a good size.

These results, the author said, should certainly encourage us in our attempts to promote immediate union of the urethra when divided by violence. The operation was not a difficult one. A median incision opens the blood cavity about the urethra. After the clots have been turned out a sound passed quickly down the urethra shows us the anterior end. If the urethra is not fully divided, the rent is then easily seen and rapidly repaired. When the division has been complete, the posterior end may not be so easily found, but in a rupture due to a crushing accident the profuse bleeding which occurs from the bulb of the urethra, instead of obscuring our search, serves as a guide to that which we are seeking. If the bleeding point in the posterior part of the wound is seized with forceps and pulled forward, the collapsed and retracted end of the urethra will be brought to view. In a case of longer standing, when the bleeding has stopped, the search may be more difficult, in which event firm pressure should be made above the pubes to force the escape of urine to serve as a guide. In all these cases the suture was made with interrupted catgut stitches, which were all placed before any of them were tied. Care was taken to include only the cavernous and muscular tissue in the stitches, and not to encroach on the mucous membrane. In every case, upon tying the stitches, the hæmorrhage immediately stopped. The conclusions of the author were as follows :

1. In every case of ruptured urethra, immediate perineal section, with suture of the urethra, should be practiced.

2. By this procedure not only do we greatly lessen the danger of urine infiltration and abscess, but we also, in a large proportion of cases, may hope to prevent the formation of close, intractable strictures.

3. In the early operation the search for the posterior end of the urethra is much easier than in the later. The hæmorrhage from the branch of the artery of the bulb serves as a guide to that end of the canal.

DR. J. WILLIAM WHITE, of Philadelphia, said that he fully concurred with Dr. Cabot in the general principles laid down in his paper. There was another class of cases, however, in which it was sometimes difficult to decide just what procedure to follow—namely, cases of slight injury, in which there were practically no symptoms excepting a little hæmorrhage, and perhaps some perineal swelling. In a slight, partial rupture of this character, was the outlook from suturing any better than we could expect from the introduction and retention of a large-sized instrument, and careful urinary anti-

sepsis? The latter course is the one that would probably be pursued by the majority of genito-urinary surgeons in such cases.

Dr. James P. Tuttle, of New York, inquired whether it was necessary to freshen the edges of the ruptured urethra in the cases where operation was not performed immediately after the accident?

Dr. F. Tilden Brown, of New York, inquired if the bulb was the region affected in all of Dr. Cabot's cases?

Dr. John P. Bryson, of St. Louis, said he was fully in accord with the statement made by Dr. Cabot that an early operation was demanded in a case of traumatic rupture of the urethra. If it can be demonstrated that the lesion in the urethra is transverse or oblique, the indications are to open and suture it. In these cases we often have to deal with a semilunar laceration. In one or two cases coming under his observation, where the bladder had to be opened to find the posterior segment of the urethra, the results were not good, so far as the prevention of cicatricial stricture—the so-called traumatic stricture—was concerned. In one instance the whole of the urethra from the apex of the prostate to the anterior division was torn away by the surgeon in an effort to find and replace it. The primary operation should be done wherever it is possible.

Dr. F. R. Sturgis, of New York, said that in some of these cases, in an effort to suture the urethra, too much was done by the surgeon, and too much was sometimes as bad as too little. When the rupture is slight the introduction of an instrument to keep the canal patent is often all that is necessary. When, on the contrary, the rupture is extensive, an operation was called for.

Dr. Abner Post, of Boston, reported the following case which came under his observation during the past year: The patient was a man who met with a severe fall. On recovering consciousness he had no idea that he had injured his urethra until he found that he was unable to pass his water. On examination it was found that the perineum was slightly swollen. The urethra was cut down upon and a complete rupture discovered. It was difficult to locate the posterior end of the canal until the finger was introduced into the rectum and the perineum lifted. A few days ago a case of partial rupture came under his observation; catheterization was so easily accomplished that the instrument was not allowed to remain *in situ*. The catheterization was repeated three times with perfect safety, but the fourth time it was found impossible to introduce it. An incision through the perineum showed that the obstruction was due to a longitudinal rent in the urethra. There was great temptation in that case to allow it to go on without further operation; the man emptied his bladder so well that he absolutely refused any surgical interference until twenty-four hours later, when he had a serious chill. That patient would have been better off had an immediate operation been performed, and the urethra sutured.

Dr. George Chismore, of San Francisco, said that while he coincided with the views of the author of the paper in every respect, yet it seemed to him that we were a little premature in concluding that a rupture of the urethra, not sutured, and left to the healing powers of Nature alone, would invariably lead to a particularly intractable form of stricture, or would of necessity produce such a form of stricture. The following case, which came under his observation, bears on this point: Ten years ago he was called by

another physician to see a gentleman who had fallen across a buggy wheel on the previous day; this had produced a rupture of the urethra; there was complete retention and infiltration of urine into the perineum. It being impossible to introduce an instrument through the urethra, perineal section was done without a guide, and the bladder allowed to drain for a few days. As it was then possible to traverse the urethra, he was catheterized regularly, and in due course he recovered. He was warned of the danger of a stricture, which, in that case, it seemed, could hardly be avoided. Nothing further was seen of the patient until last year, when he returned to Dr. Chismore complaining of symptoms of stricture, and informing him that he had had his doctor pass sounds for a month or so after the operation, and that he had had no instrument passed since. On examination a stricture was found at the seat of the injury; it admitted a filiform bougie, and over this a small-sized tunneled sound was passed. The stricture yielded very readily, admitting, within two weeks, a No. 10 F. The dilatable condition of the stricture in the above case, Dr. Chismore said, has made him a little chary of accepting the theory that the inevitable result of such injuries is an intractable form of stricture.

DR. BRYSON said that in the linear form of stricture, which is usually a simple band rising quite sharply from the urethral wall, dilatation would often produce good results, and sometimes bring about a radical cure. The direction of the lesion has much to do with the surgeon's work. A longitudinal tear may heal even without the use of a catheter, but in traumatic cases the rupture is usually transverse or oblique. The difficulty is that we were not able to appreciate exactly what kind of an injury we have to deal with. In one case, coming under the speaker's observation, the urethra was torn across in front of the triangular ligament; the posterior portion was invaginated and pushed well back into the prostatic sinus. It was drawn forward and stitched to the anterior end of the urethra; the result has been entirely satisfactory.

DR. CABOT, in closing the discussion, said he agreed with the statement made by Dr. White, that it is often difficult to decide whether a case required immediate operation or whether milder measures would suffice. The feeling he had is that if a case which does require early operation is not operated on, it usually does badly. An abscess resulted, together with a cicatricial stricture, which might have been avoided by immediate operation. The actual danger pertaining to such an operation was trivial. It was a much more serious matter if we left a blood-clot or a tear in the mucous membrane. In cases of doubt, therefore, it was well to operate. There were undoubtedly cases where the injury was so slight that we could treat them as indicated by Dr. White, but where there was inability to pass a catheter, or a large swelling in the perineum, an operation was necessary. There is more danger of infection from the passage of instruments than from an open wound, made under antiseptic conditions. The speaker said that in all his cases he left the outer wound open, nor did he stitch the mucous membrane of the urethra, as he had found that by suturing the muscular and cavernous tissues surrounding the canal the two edges of the mucous membrane are brought in close apposition. In all his cases the operation was done so soon after the receipt of the injury that he did not find it necessary to refresh the edges of the tissues. In all his cases the rupture was at or in the neighborhood of the bulb.

In closing his remarks, the speaker said he was surprised to find in most of the published reports of cases in which this operation was done an excuse or apology offered for doing it. The results of immediate operative interference have thus far been so excellent that he did not think an apology was necessary. He agreed with Dr. Bryson that after complete rupture of the urethra the posterior portion often retracts to a surprising extent—almost like the end of a severed artery. In the case related by Dr. Chismore, the good result was no doubt partly due to the fact that a perineal opening was made, thus preventing urinary infiltration.

Report of Two Cases of Urethrectomy with Transplantation for Urethral Strictures.*—By Dr. John P. Bryson, of St. Louis.

Good Results following Urethral Resection.—Dr. Eugene Fuller, of New York, read a paper with this title. He stated that during the past year he had encountered two cases in which, owing to the extensive destruction of the urethral canal, he had originally expected to be obliged to establish an artificial route (either perineal or hypogastric) in order to insure a satisfactory and permanent outlet for the vesical contents. In both of these cases, however, by resorting to a very radical and extensive excision of the diseased urethral areas, including also the surrounding perineal cicatrices, he was able to restore the normal urinary function, and to leave the urethral canals apparently permanently of good caliber. In one of the cases the excised tissue included the entire bulbous urethra, fully an inch of the penile urethra anterior to the bulb, and the anterior half inch of the membranous urethra. In the other case an inch and three quarters of the urethra was removed. In this second case the tissue removed included the bulbous urethra and the anterior portion of the membranous urethra.

The first case was operated on about one year ago, and has been under observation ever since. Although the urethra is somewhat tortuous, it admits freely an 18 A., and shows no special tendency to contract. The second case, which was done about ten months ago, admitted a 17 A. easily four months after the operation; since that time, Dr. Fuller said, he has not had an opportunity personally to examine the patient, although he had heard from him that he is all right, and in no apparent need of surgical attention.

As an after treatment in his cases, the speaker said he had adopted a method which has all the advantages of the "*sonde à demeure*," without its disadvantages. It was described as follows: After the resection has been accomplished, he made a very low cut, dividing the deepest portion of the membranous urethra, the lowest portion of the perineal structures, and some of the circular fibers of the sphincter ani. Along this low-level route he placed a large-sized soft rubber vesical drainage tube. He then introduced along the urethra a soft catheter of such a caliber that it can be retained with comfort. This catheter extends from the meatus along the penile, the resected, and the deep urethra down to the big perineal tube, and about it the perineal structures are carefully sutured. This urethral tube was kept in for a week or ten days, as the case may be. The large perineal tube can be withdrawn and replaced, if necessary, without in the least disturbing the urethral tube.

* Will be published.

The following was one of the cases reported by Dr. Fuller: Male, aged forty-five years. In early life he had had numerous attacks of gonorrhœa. Ten years ago he first began to suffer from obstruction to urination, due to stricture. Shortly after that he was seized with an attack of retention of urine, which was relieved by instruments. Later his stricture recontracted, and he again had retention, complicated with perineal extravasation. This was followed by abscess and perineal fistulæ. Numerous halfway attempts had since been made to relieve his condition by instrumentation, and cutting and draining the perineal abscesses; all these attempts, however, had proved complete failures. When he first came under Dr. Fuller's observation his perineum and entire scrotum were one mass of hard induration, riddled with fistulæ. The tumefaction caused by the induration prevented him from sitting upright. No urine passed or had passed for a considerable period along the penile urethra, but leaked its way constantly out through the numerous fistulæ. After improving his general health as much as possible an operation was undertaken. With whalebone filiform bougies the chief fistulous tracts were located. With these for landmarks, a long, straight median incision was made, exending from the penile urethra in front of the scrotum, down to and partially including the sphincter ani. The cut split the scrotum, a testicle lying on either side of it. The whole length of the abscess cavity was exposed. The entire bulbous urethra, an inch of the penile urethra anterior to the bulb, and the anterior half inch of the membranous urethra were found to be in a state of thorough disorganization. Fistulous tracts extended entirely around that portion of the urethra, showing that burrowing pus had dissected the canal free from its adjacent tissues, leaving that space to be filled in with a dense cicatrix. Besides burrowing about the urethra, purulent extravasation had invaded the tissues about the groin and rectum. From the median incision radiating incisions were made, laying open all these adjacent pockets. The diseased urethra existed as a hard, fibrous cord, perforated in numerous places, and so disorganized and contracted that, on being split open by an incision, little remained to mark the course of the urethral canal. This disorganized urethra was carefully cut out, and the cicatricial indurations from the perineum and scrotum were also removed. In fact, so much tissue was removed from the perineum that in one place little was left save the skin and subcutaneous tissues. A perineal vesical tube and a urethral tube were then put in place, in the manner above described, and the perineum and scrotum were carefully sutured about the urethral tube. The latter was kept in place for ten days, and the perineal tube for nearly three weeks. The perineal wound healed by first intention, excepting in one spot, where little save skin and subcutaneous tissues had been left. In this spot a fistulous opening remained for a time, but at the end of six weeks it closed permanently. At about the same time the perineal tract along which the vesical tube passed closed. It is now a year since the operation; the patient is perfectly comfortable, he urinates normally, and a No. 18 A. sound can be inserted without difficulty.

DR. WHITE said that in one case of injury to the urethra coming under his observation a considerable portion of the urethral wall was missing: to fill this gap he used a graft taken from the mucous membrane on the inside of the cheek. He was unable to say whether the graft took successfully or not, but he noticed that during the few days it remained in view it became

quite pale. The case did well, however, and he was disposed to think that the transplantation was a factor in bringing about the good result.

Dr. Bryson expressed the opinion that in the cases reported by Dr. Fuller, particularly in the last one, the time that has elapsed since the operation was too short to enable him to pronounce them permanently cured. In a case of that character, where an extensive resection is done, it would no doubt take a considerable period of time for the urinary canal to fill up. At least five or six years should elapse before a permanent cure could be predicted. One point alluded to by Dr. Fuller was very interesting—namely, the difficulty experienced in the majority of cases of maintaining the perineal opening patulous long enough to see what really does take place. In one case where he operated he was able for over two weeks to see the roof of the urethra and inspect the condition of the graft. He felt quite satisfied that it took thoroughly. Dr. Bryson said that resection of the urethra for stricture had been practiced for many years ; it was alluded to by all the older writers and by some it has been condemned on the ground that it converted an organic stricture into a traumatic one; in other words, that it took away the mucous membrane, if any existed.

Dr. Chismore expressed the opinion that the result of grafts within the urethra must be very uncertain. Even in the ordinary skin-grafting on the surface the grafts are apt to curl and crimple, and in a circular tube like the urethra it is hardly possible that they can be retained with any degree of certainty. Perhaps the good results that have been reported in cases where grafts were employed took place in spite of the grafting rather than because of it.

Dr. Fuller, in closing the discussion, said he was so well satisfied with the results obtained in his cases, that he did not think it was necessary to resort to grafting. He was inclined to think that the good results obtained with grafts were due to the fact that resection had been employed, rather than to the grafts themselves. It was necessary to cut away all the nodular tissue before the grafts could be put in, and then we were very uncertain whether they would take or not. By keeping the perineal wound open for so long a time as Dr. Bryson did, we were more apt to get a cicatrix.

Dr. Bryson said that in the first case where he employed grafts there was a suppurative urethritis, and for this reason it was necessary to keep the perineal wound open. In the second case an immediate transplantation was done, and the success of the grafts was all that one could hope for.

Movable Kidney: Its Frequency; its Causal Relation to Certain Definite Symptoms; the Measure of Relief afforded by Nephrorrhaphy; a New Method of applying Sutures in the Operation.—Dr. Francis S. Watson, of Boston, read a paper with this title. He stated that the importance of this subject was not sufficiently recognized in this country, in spite of a large mass of reliable data which is at the disposal of the profession. He quoted the remarks of Morris, in the *Lancet* of July, 1893, as follows: "A few years ago it was gravely asserted by a distinguished surgeon that movable kidney was a myth; that it was a thing of no pathological significance; that cases of mobile kidney were in reality tumors of other organs; that in the few cases of mobile kidney which have been observed at post-mortems the condition had not been suspected during life. It was asserted by a speaker at a recent meeting of the Royal Medical and Surgical Society that he had found but

two cases of movable kidney in four thousand post-mortem examinations. Another speaker stated that women who are subject to this condition suffer from a little occasional dragging pain in the side, but otherwise usually have no symptoms."

Movable kidney, Dr. Watson said, is regarded by many intelligent surgeons as a fad; by others as merely one manifestation of hysteria. Eminent pathologists continue to assert its great rarity, and mention of successful nephrorraphies is met with a shrug of the shoulder. The reasons for these doubts are probably as follows: The pathologist rarely finds movable kidney because, in the first place, he rarely looks for it; and in the second place, as Newman and Kendal Franks have pointed out, with the body in the dorsal position the kidney naturally returns to its normal position and afterward is retained there by the solidification of the perinephritic fat after death. Those who speak of the condition as a fad generally rest their disbelief upon no better basis than the fact that they have seen a few women with hysterical symptoms who, before they were told that they had a floating kidney, had never thought anything about that organ, but afterward constantly referred the great variety of symptoms to their movable kidney, and to having met with a few instances in which the symptoms persisted after nephrorrhaphy, or having been told of some in which the kidney fell down again after operation. Another and important reason is that of failure to find a movable kidney which has been asserted to be present either by the patient or the physician in attendance; but this failure has but little significance in view of the fact that the movable kidney frequently disappears. When it is plainly to be felt in an abnormal position all the time, it is no longer a movable kidney, but usually one which has become fixed in its abnormal position and is hydronephrotic.

As regards the frequency of this condition, the following figures will prove of interest: Glenard, in 1893, reported that he had seen personally, between 1885 and 1893, five hundred and thirty-seven cases of movable kidney. Lindner, in 1888, asserted that one woman in every five was subject to movable kidney. Edebohls, in 1893, said that he had found ninety cases in a series of five hundred women examined.

Glenard, who is perhaps the strongest of all believers in the great frequency of movable kidney, denies that there are any symptoms to be referred to it *per se*: he asserts that it is always associated with enteroptosis, and that all symptoms are to be referred to this latter condition. Others, in less degree, maintain Glenard's view, while Trasteur summarizes his belief in the characteristic French sentence, "*Le rein mobile est le satellite de l'entéroptose.*" Others consider that all the symptoms are referable to disorders of other organs, notably those of the sexual apparatus in women. Others assume that because similar symptoms have been found in connection with other abnormal tumors, which have been erroneously diagnosticated as movable kidney, therefore there are no symptoms which belong to the latter condition. Glenard's view as to the dependence of the symptoms upon enteroptosis and not upon the movable kidney is readily disproved by the fact that any observer of very small experience can easily assure himself that there are many cases of movable kidney—in fact, the majority—in which no enteroptosis is present. As a final and convincing proof of the dependence of symptoms upon the movable kidney is another fact which can not be set

aside—namely, the numerous cases of nephrorrhaphy in which the operation has been followed by a total disappearance of the symptoms, and in many instances by permanent relief.

There are three symptoms of the dependence of which upon movable kidney all authorities agree. These are, in their order of frequency, (1) pain in the loin or abdomen; (2) disturbance of digestion of the character of atonic dyspepsia; (3) neurasthenic or hysterical symptoms. There is one other which is not often mentioned, but which when present is the most characteristic of all—namely, the sickening pain, accompanied by a sense of nausea and faintness, which occurs when the kidney is grasped between the hands or the fingers and thumb. It is just as characteristic, so far as one may judge from the description of patients, as is the peculiar sensation which men feel when the testicle is squeezed.

The pain is usually in inverse proportion to the degree of mobility of the organ. Those patients who have true floating kidney, with long mesonephron, generally escape with the least degree of pain or have none at all.

An important point in connection with this condition is the occurrence, in a considerable number of cases, of hydronephrosis, which, beginning as intermittent, sometimes becomes permanent, and the original gravity of which is occasionally added to by infection from the lower part of the urinary tract, converting it into a pyonephrosis, with destruction of the organ.

In 1892 Neumann collected 283 cases showing the results of nephrorrhaphy for the relief of this condition. Of these, 65 per cent were cured, 18 per cent relieved, and 20 per cent were failures; 1·82 per cent died. Tuffier, in 1893, reported 45 cases in which he had performed nephrorrhaphy for movable kidney three or more years before, and in all of them the immediate result had been good.

After briefly describing the various methods of performing the operation, Dr. Watson gave his own method of suturing the kidney in the loin, which was as follows: After exposing the kidney by the usual lumbar incision along the margin of the quadratus lumborum, the fatty capsule covering the posterior surface of the kidney is excised, and its cut edges are stitched a little distance within the margins of the wound. Two stout chromacized catgut sutures are then passed through two thirds of the entire length of the kidney, parallel to each other, and through the parenchyma of the organ, at a distance of half an inch from each other. They enter the kidney a little above its lower end, and emerge a little below its upper end. Either end of the suture is then passed through the edge of the muscular layer of the wound. Two other sutures are then passed in a horizontal direction through the substance of the kidney, one above and one below the points of entrance and of issue of the first two sutures, and their ends are also passed through the muscular borders of the lumbar wound. The fibrous capsule is now split throughout nearly the entire extent of the posterior surface of the organ, and reflected to a very slight extent toward either side, thus denuding the posterior border of the kidney to the breadth of the little finger. The sutures, instead of being tied in the ordinary way—that is to say, instead of each end being tied to the opposite end of the same suture—the end of one long suture is tied to the end of the other above and the same is done below at the points where they pass parallel to each other through the muscular layer. The same is done with the cross sutures. In this way the danger of the stitches

tearing out is avoided. The kidney is drawn firmly into its place and maintained there by the sutures, being suspended as in a hammock.

Dr. Watson said he had employed the above method with entire success in three cases.

DR. CHISMORE stated that while he knew very little about the subject of movable kidney, Dr. Watson's paper had made such an impression on him that he would pay more attention to it in the future. He had noticed that certain of his colleagues find movable and floating kidneys with remarkable frequency, whereas he had detected this condition very rarely; he had even failed to find it in cases where that diagnosis had been previously made by some one else. He had, however, one undoubted case of floating kidney under his observation at present, the degree of mobility being so pronounced that the organ could be felt through the anterior abdominal wall and moved about in every direction. In that particular case the condition was discovered by accident, and as it had given rise to no marked symptoms, nothing had been done regarding it. Another patient is under his care in whom a distinguished Baltimore surgeon found a movable kidney and urgently advised immediate operation: Dr. Chismore, after repeated examinations, had been unable to confirm that diagnosis. This failure might be attributed, perhaps, to his imperfect method of examination, as he had hitherto regarded the condition as one for which there seemed to be a rage to operate at present.

DR. CABOT said he had operated on quite a number of cases of movable kidney which had given rise to symptoms in different degrees. In some cases the condition gave rise to nervous symptoms, in others to digestive disturbances, and in a third class it caused kidney colic. In the digestive and still more in the latter class of cases the most favorable results were obtained by operative interference. He had only observed one case in a male. This was a young man, who was referred to him by Dr. Shattuck, who suffered from extreme nausea and vomiting, together with loss of weight and strength. The mobility of the kidney was so slight that Dr. Cabot at first doubted the advisability of an operation. The result of the operation, however, was excellent; the patient rapidly gained in weight, his gastric symptoms disappeared, and he has remained well since. In cases where the nervous symptoms predominate his experience with the operation has been less favorable. In another case coming under his observation, that of a woman who was subject to attacks of renal colic, he found that the kidney had fallen forward so that the upper end of the organ presented anteriorly close to the umbilicus. The case was operated on three or four months ago, and the immediate result was good; since then he had not heard from the patient. He had operated on one case in which a relapse occurred within three or four months. This was one of his earlier cases in which he put the stitches well through the kidney substance and capsule and stitched the muscles and fascia behind; the stitches were tied pretty firmly and probably cut through. In his later cases he had adopted the method originated by Guyon, which seemed to work very well. Briefly, the technique of that operation is as follows: Pass a double thread through the fascia and muscle to which you wish to attach the kidney, and then pass it through the kidney substance. Tie a knot some little distance down at the free ends of the thread and then bring this knot down against the outer side of the kidney. Cut off your needle and tie a similar knot on the opposite side, so that you have a knot on

each side of the kidney with a double thread running through the organ. You then take your stitch through the muscle. The knot on each side prevents the kidney substance from being cut. Guyon refers to the danger of the top of the kidney falling forward, and he avoids this by taking one of his stitches high up, through the upper third of the kidney; he takes another through the middle and one through the lower third, and then brings them up toward the tewelfth rib. By following this method the kidney can not fall forward. He thought the method described by Dr. Watson would be applicable where the kidney is not fixed above the twelfth rib.

Dr. Watson said that in regard to this very point of location he had followed a suggestion made to him some time ago by Dr. Cabot—namely, that the best point to fix the kidney was at a level with the lowest plane which it reached during respiration. He had found that this was an exceedingly comfortable location, and it was usually not much above the twelfth rib.

Dr. Cabot said that in his last three cases at least one half the kidney was above the twelfth rib.

Dr. White said that in a considerable proportion of the cases where he had operated for movable kidney the patients were men. He was quite well satisfied that this condition existed far more frequently than many suppose. He was equally well satisfied that too many movable kidneys were being found and operated on to-day. We were now fairly well acquainted with the symptoms which this condition gave rise to. He had never seen a death result from the operation, and he had never failed to get at least temporary relief. The diagnosis usually rested between movable kidney and tumor of the gall bladder or some other intra-abdominal condition. One of the symptoms to aid us in making a diagnosis of movable kidney is the variation in the quantity of urine passed: we may get a history of diminution in the amount passed, followed by a sudden increase and a relief of the symptoms due to torsion of the ureter. The diagnosis between movable kidney and enlarged gall bladder might be exceedingly difficult. Absence of jaundice and other physical signs may aid us. The symptom mentioned in most of the textbooks—namely, percussion over the loin—he regarded as of very little importance. The speaker expressed the opinion that most of the symptoms accompanying movable kidney were directly due to the condition itself, and were not of an hysterical character. The traction on the duodenum would account for the gastric phenomena, the obstruction to the outflow of urine would account for the renal symptoms, and the traction on the nerves would account for the nervous manifestations. As to the location where the kidney should be anchored, Dr. White said he did not regard this as a very important point. The symptoms were probably due to the twisting or rotation of the kidney.

Dr. Fuller called attention to the fact that in cases where the capsule of the kidney was incised a plastic lymph is thrown out which becomes firm and holds the organ in place. He had seen cases where firm adhesions of the kidney were thus formed. In some cases the propriety of operating on both sides came up. He referred to the case of a young woman upon whom Dr. Keyes operated for movable kidney five or six years ago; her symptoms were entirely relieved for several years, but lately she developed similar symptoms on the opposite side, which were also due to a movable kidney.

Dr. Bryson said that an important reason for operating in these cases

was the danger of suppurative lesions. In four cases where he had opened the kidney for the purpose of draining a suppurating pelvis he found the kidney much lower down than it should have been, and so far as he could ascertain, the obstruction had taken place about the brim of the false pelvis, where the ureter is apt to kink when the kidney becomes displaced. The speaker said he agreed perfectly with Dr. Watson regarding the characteristic pain produced by compressing the kidney. It resembles the feeling produced by squeezing the testicle, and this is what we might expect, as the latter, so far as its nerve and blood supply are concerned, is an abdominal organ. He agreed with Dr. White that percussion of the loin is an utterly worthless procedure for determining the presence or absence of the kidney in that region. The speaker said he regarded nephrorrhaphy as a very painful operation, as a rule. The pain, it seems, passes along the line of the twelfth intercostal and first lumbar nerves, and in operating on these cases he had endeavored to draw these nerves aside, so as not to include them in the ligature. In one case where he operated, in introducing his ligature, he tapped the pelvis of the kidney, resulting in urine leakage; the condition was not recognized until several days had elapsed, when he was obliged to reopen the wound and drain the kidney. In that case the kidney became firmly fixed in position by the lymph exudate to which Dr. Fuller referred in his remarks. As regards the proper location of the organ, he had obtained the best results by fixing it in a position where the ureter is neither stretched nor relaxed enough to become kinked. This position on the right side is about opposite the stump of the twelfth rib; on the left side, a little higher up. In conclusion, Dr. Bryson said he intended to adopt the method of suturing the kidney described by Dr. Watson, for the reason that he had had so much difficulty heretofore with the tearing out of the sutures.

DR. WATSON, in closing the discussion, said he was fully in accord with the statement made by Dr. White, that movable kidney is a much more common condition than we formerly supposed. If we look for these cases we will find them. Movable kidney has been referred to by various writers as a causative factor in hydro- and pyo-nephrosis. Regarding the technique of the operation, Dr. Watson said he regarded splitting the capsule as an important step, but not denudation of the kidney. The exudation of plastic lymph helps materially in fixing the organ.

Correspondence.

PROPOSED INTERNATIONAL CONGRESS FOR THE SUPPRESSION OF LEPROSY.

210 WEST 4TH ST., NEW YORK, *February 18, 1896.*

Editor of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES :

DEAR SIR : I have the honor to inclose a correspondence I had with Dr. Jules Goldschmidt, of Paris, France, regarding the question of an international congress for the suppression of leprosy. Will you kindly bring the

matter to the attention of the American Dermatological Association, of which body I myself am not a member? Very sincerely yours,

ALBERT S. ASHMEAD.

PARIS, *26th December, 1895.*

DEAR DR. ASHMEAD: . . . A few days ago I sent to your address a number of the *Bulletin médical* of this city, containing my last publication on leprosy. To day I send you my little book on *Lèpre à Madère.*

You will see that the prophylaxis of this foul disease occupies my mind very much. However, to come to a decision on the best mode of exterminating the endemic, and to preserve other countries (fully or partially free), we must form an opinion on the ætiology.

Your publications confirm my firm belief that the disease is spreading by direct contact from man to man, without any intermediate condition!

I see the great interest which you devote to the study of leprosy, and therefore I should like to submit to you my idea to form an international committee for the suppression of this plague. My wish is to interest all governments concerned (and few only are not concerned), and to convoke a congress in order to have stringent prophylactic measures adopted. These measures are to be carried out by all civilized nations. . . .

I remain, etc., J. GOLDSCHMIDT.

[Dr. Goldschmidt spent twenty-six years in the island of Madeira in charge of the leper hospital of Funchal. The island of Madeira was discovered in 1419. The city of Funchal was soon its prosperous capital. In spite of the purity of the air, and the climate which knows hardly any other season but spring, lepra spread there almost as soon as it became inhabited. The Portuguese discoverers were the first inhabitants. Before the end of the fifteenth century a leprosery was established there.]

NEW YORK, *January 9, 1896.*

DEAR DR. GOLDSCHMIDT: I have received your letter and the book on leprosy in Madeira. The *Medical Bulletin* did not come to hand; it probably came to grief in the mail.

I have sent to Hansen, and to Havelburg of Rio Janeiro, also to the medical dons of Japan, a copy of that part of your letter in which you suggest the convocation of a congress. As far as Japan is concerned, of which I can speak with perfect knowledge, the Government would not take any steps in that direction; for it is an obstinate as well as traditional resolution on the part of the whole Japanese people to ignore and even deny absolutely the existence of leprosy in their country. It is one of the forms which patriotism has taken in those islands. Neither in statistics nor in medical discussions will this tabooed subject ever be mooted. Yet there are (*hinc illud silentium*) 100,000 lepers in the country; in one village, very well known to me, there are 1,300. Dr. Putnam, of Colombia, South America, where there are 27,000 lepers, says also that the Government of the republic entirely ignores the question, and he publishes a letter of the governor, declaring that he will have nothing to do with this pathological business. I can assure you that there are many countries (for instance, Japan) where, if the Government interfered by any stringent measure for the suppression of leprosy, there would be simply civil war. Believe me, there is no exaggeration in that.

Very truly yours, ALBERT S. ASHMEAD.

PARIS, *1st February, 1896.*

DEAR DR. ASHMEAD: I am exceedingly obliged for your interesting letter of January 9th, and I have taken good note of it. What you say about Japan and Colombia, South America, is very disheartening, but still I think if I can get the English, French, and American Governments to act jointly in this matter, other governments would follow easily. The United States are much interested in this question—viz., the suppression of leprosy—for, as you have pointed out yourself, the danger exists and may become, from known or hitherto unknown sources, any time a very urgent one.

Will you take it upon yourself to obtain a decision from your Government how far it is willing to join an international congress which has to discuss and propose measures for the suppression and the prevention of leprosy?

As soon as I am in receipt of your answer I shall follow up the subject with the English Government. . . . Yours sincerely,

J. GOLDSCHMIDT.

Selections.

The Relationship of Purpura Rheumatica to Erythema Exsudativum Multiforme. STEPHEN MACKENZIE (*Brit. Journ. of Derm.*, April, 1896, p. 113).

The author reviews the group of rheumatic symptoms, arthritis, inflammation of serous membranes, chorea, tonsillitis, exudative erythema, and purpura, pointing out that we find sometimes one, sometimes another leading in the chain of events, and that any one occurring alone should be viewed with suspicion. He gives the histories of three cases of rheumatic purpura and one of polymorphic erythema, all of them complicated by visceral derangements identical with those pointed out by Osler (for abstract of his article, see April number of this JOURNAL). One of the purpuric cases had a fatal termination. The conclusions reached are that purpura rheumatica is an expression of rheumatism, and while it may be associated with erythema, it is often purely hæmorrhagic. From its definite characters and uniform course it should be recognized as a distinct clinical type, though essentially of the nature of polymorphic erythema. J. C. J.

Erythema Multiforme. A Clinical and Bacteriological Note. M. CARRUCCIO (*Clin. Dermosifilopatica della R. Univers. di Roma*, March 29, 1895).

The patient had a typical attack of multiform erythema of a papulo-vesicular type. An increase of eosinophile cells was found in his blood. The vesicles seated in the stratum mucosum contained blood corpuscles, red and white, and clusters of micrococci, which were found also between the prickle cells and were cultivated on various media. Campana and Finger have reported similar cases. The author thinks that micro-organisms, equally with poisons (arsenic, serotherapy) and disease (typhus, rheumatism), may give rise to the cutaneous affection in question.

Senile Purpura. P. G. UNNA (*Journ. des mal. cut. et syph.*, March, 1896, p. 129).

Unna asks these questions: Is the purpura due to vascular rupture or to diapedesis? Is the purpura a final and necessary consequence of cutaneous degeneration, or do the two processes advance side by side without relation of cause and effect; or, finally, is the hæmorrhage not the first cause of the skin degeneration? In answer to the first, he says that it appears correct to consider senile purpura as a diapedetic hæmorrhage, not forgetting that here and there a slight traumatism (scratching) may produce in a degenerated skin a rupture with great ecchymosis, which extends in the places where degeneration is at its maximum. After study of his preparations, it is impossible to admit that hæmorrhage is a simple consequence of degenerescence, since the latter does not always precede vascular rupture, and is not always found in the midst of a focus of degeneration. The two symptoms are not derived from one another, but are co-ordinated. The extravasated blood does, moreover, exert a harmful influence on the surrounding collagenous and elastic tissue. All senile changes, however, can not be attributed to hæmorrhage, since alterations may take place in the skin of the face without antecedent extravasation. J. C. J.

Generalized, Idiopathic Cutaneous Sarcoma with Giant Cells. PERRIN and LEREDDE (*Annales de derm. et de syph.*, November, 1895).

The histological types of sarcoma are most variable. The authors' case belongs to the nonpigmented variety. The tumors were present on the woman's face and the external aspects of the arms. There were no enlarged glands, no pain, or tenderness. The neoplasms grew slowly, did not ulcerate, and displayed no tendency to spontaneous disappearance or pigmentation. They were removed by operation. Histologically, they were made of closely aggregated nodules, separated by connective tissue, and situated between the papillary layer and the subcutaneous muscle. The individual cells were identical with connective-tissue corpuscles, except that at the margins and scattered through the nodules large multinuclear giant cells were seen. Around the vessels were groups of round cells, lymphocytes and basophiles (plasma cells), different from the fundamental tumor elements, and giving the impression of an infection. J. C. J.

A New Form of Suppurative and Pemphigoid Tuberculosis of the Skin in Patches with Eccentric Progression. H. HALLOPEAU (*Annales de derm. et de syph.*, December, 1895).

The patient was a youth of fifteen, with a clear family history of tuberculosis, who had the disease himself in an advanced form. His eruption was thickly set and of varied type on the limbs, more widely disseminated on the body. It consisted of (1) numerous tiny pustules scattered over the legs; (2) small patches dotted here and there, made up of grouped nodules resembling those of lupus; (3) small papules over abdomen and forearms like those of lichen scrofulosorum; (4) patches, two or three in number on each calf, two to eight centimetres in diameter, made up of red, elevated, indurated, tumorlike growths, rounded or oval, with many small pustules, and in some a bullous formation at the edges. The central portion of the plaques was ulcerated or cicatrized.

From his study of the case the author draws a few conclusions. Pustular tuberculosis in young people may cause deep infiltrations of the derma, rapidly involving the epidermis, and forming rounded nodules which may ulcerate. These ulcerations are due to the formation and rupture of small pustules in the lesion which are seated commonly about a hair follicle. They cicatrize rapidly, and the marginal epidermis may be raised in pemphigoid elevations, hitherto undescribed in connection with skin tuberculosis. Lupous nodules and the papules of lichen scrofulosorum may be present with these lesions. J. C. J.

Parasitophobic Neurodermites. L. PERRIN (*Annales de derm. et de syph.*, t. vii, No. 2, February, 1896).

Diagnosis of the affection is ordinarily easy. The patients, in recounting their histories, soon make it plain that the disease of which they complain exists only in their imaginations. Hypochondria with obsession is manifest. The accounts of the beginning of the trouble, the subjective symptoms complained of, the absence of every cutaneous lesion of parasitic origin, are the facts which indicate a profound alteration in the intellectual faculties. Dangerous hallucinations may complicate the disease. Parasitophobias may be primary or secondary—i. e., they may occur with or without preceding invasion by parasites. In the latter case it is a true stigma of mental degeneration. The affection being psychic, it is to that element to which treatment should be directed. Suggestion may be tried, but the best plan is to convince the patients of a cure by treatment calculated to calm the general nervous system and pruritus. The author gives three cases.

J. C. J.

The Cutaneous Manifestations of Diabetes. PRINCE A. MORROW (*Medical Record*, April 11, 1896).

Diabetic dermatoses are divided into two classes—those which form part of the symptomatology of the disease, are of the same origin and nature, and those which occur incidentally and with comparative infrequency in its course. In the first class, one of the earliest derangements is functional disorder of the sweat and sebaceous glands. *Asteatosis* and *anidrosis* are the usual manifestations, but hyperidrosis, especially unilateral, may be present. Trophic changes in the skin usually attend this disturbance. Another habitual expression is *paræsthesia*, its most common form being pruritus, general or localized, as of the genitalia. *Defluvium capillorum* results from trophic changes in follicles and glands. Alopecia may be complete. The nails may be lost or atrophied by *paronychia diabetica*. In advanced cases gangrene may appear. Falling of the nails like the teeth may occur at an early stage. Among the *eruptive disorders* are classed erythema and *eczema*, the latter often occurring about the genitals and characterized by extreme severity. Hyperplastic infiltration is marked. *Balanitis* and *balano-posthitis* usually begin as an erythema of the meatus. In the latter, diabetic phimosis may supervene. The prepuce is thickened, indurated, and fissured. *Furuncles* are the most common cutaneous manifestation of diabetes, carbuncles and phlegmons being less frequent. They develop usually on the back, neck, and buttocks. The disease creates a special predisposition to *gangrene*, which may be primitive or consecutive to any lesion. It may be single, is usually moist,

and may be preceded by bullæ. It is most liable to occur in fat persons, and its frequency increases with age. Alcoholic diabetics are particularly prone to it. *Xanthoma diabeticorum* is the typical dermatosis diabetica. Its features are familiar to dermatologists.

Among the second class of skin affections are mentioned chronic papular urticaria, eczematous, impetiginous, and lichenoid eruptions, bullous and pemphigoid lesions, psoriasis, acne caehecticorum, dermatitis herpetiformis, zoster, mal perforant, purpura, erysipelas, and dermatitis diabetica papillomatosa of Kaposi. A case of bronzed skin in diabetes has recently been reported by von Harndt. J. C. J.

Polymyositis Acuta, with Report of a Case presumably of Syphilitic Origin (Myositis Syphilitica). JAMES B. HERRICK (*Amer. Journ. of Med. Sciences*, April, 1896).

We shall concern ourselves only with that portion of the paper treating of the syphilitic affection. (1) Syphilitic myositis occurs in three forms—the gummatous, diffuse, and combined. (2) Diffuse syphilitic myositis is usually a late manifestation of syphilis; it appears without definite exciting cause; affects no particular muscle by preference; often involves more than one muscle; may resemble acute polymyositis. It must be distinguished also from trichinosis and polyneuritis—the former, by absence of gastro-intestinal symptoms, lack of involvement of eye muscles and diaphragm, and by failure to find trichinæ in excised muscle; the latter, by limitation to groups of muscles not nerves, absence of paræsthesiæ, trophic changes, etc. Other evidences of syphilis are of course an aid in diagnosis. Treatment consists of massage, electricity, wet dressings, mercury, and potassium iodide.

The time of its appearance varies from one to fifteen years after infection; usually, however, it is a late manifestation. In the published cases, the muscles affected varied, but the order of frequency is biceps, external sphincter ani, masseter, deltoid, sterno-mastoid, gastrocnemius. One muscle was affected in twenty-one cases, several in twenty-three cases. Histologically, in the interstitial form, there is an infiltration of round cells; later, development of fibrous tissue, the muscle fibers losing their staining capacity, their contents becoming granular, striæ lost, fibres longitudinally split. This may be combined with gumma formation, or the latter may occur alone.

Pain is the first symptom, which may be nocturnal and may radiate. False joint contractures may occur. Spasm is common and distressing in the case of the sphincter. Redness, swelling, and increase in volume are noted. Sequelæ may be atrophy and induration; later, fatty degeneration and ossification. The history of the case given is interesting and the bibliography seems to be complete. J. C. J.

Urinary Diseases in Women. HOWARD A. KELLY (*Pittsburg Med. Rev.*, January, 1896).

Dr. Kelly describes fully the use of his now well-known apparatus for the catheterization of the ureters and renal pelvis in the female, and gives these data for future guidance:

(1) In all cases of pyuria from the urethral orifice to the pelvis the location of the affected surface can easily be determined. (2) The presence of a calculus in the renal pelvis may be discovered by the renal catheter or bougie

(*a*) by bringing down bits of stone or (*b*) by scratches on or change of form of the instrument. (3) Strictures in the ureter may be precisely located. (4) Hydronephrosis can be diagnosed and differentiated from soft malignant growths. (5) Strictures of the ureter may be treated by dilating catheters or bougies. (6) Infection of the ureter and renal pelvis can, by emptying and washing out with medicated solutions, be cured without surgery. (7) This is a precise method of judging of the functional value of each kidney, judged by the amount of urine discharged and its constituents. J. C. J.

The "Capacity" of the Anterior Urethra. DR. M. DREYSEL (*Arch. für Dermat. und Syph.*, Band xxxiv, Heft 3).

Fifty men with normal urethræ were examined as to the capacity of the anterior part of the canal. For that purpose the liquid was measured that could be injected without passing the shut-off muscle.

First, in irrigations of the urethra, at a height of the fountain syringe of eighty centimetres, one hundred and thirty centimetres, and two hundred centimetres above the level of the orificium externum urethræ.

Secondly, in injections by means of a syringe containing thirty cubic centimetres, until a resistance could be felt.

The average capacity was found to be at a height of 80 centimetres, 7·8 c. c.; at a height of 130 centimetres, 10·65 c. c.; at a height of 200 centimetres, 12·9 c. c.; with the syringe, 11·8 c. c.

These figures show that the capacity of the anterior urethra is larger than generally supposed. They, of course, depend upon the resistance which the cut-off muscle offers. In some cases only five to six cubic centimetres could be injected, in others as much as twenty-two cubic centimetres, without passing the muscle.

A priori one would think that the average amount of liquid that could be injected with a syringe was larger than the one injected with an irrigator, as the pressure with the former exceeds the one in irrigations. The contrary results are explained by the author with the fact that in high irrigations the pressure is more even and takes place rather suddenly, so that the muscle contracts spasmodically, thereby offering a greater resistance than in injections with a syringe. The practical conclusions are:

1. Clap syringes, containing five to six cubic centimetres, even ten cubic centimetres, are not sufficient to distend the anterior urethra *ad maximum*.

2. With an irrigator at the usual height of about one hundred centimetres the anterior urethra is less distended than with a large syringe.

3. The maximal distention is obtained through high irrigations (two hundred centimetres), a method which *ceteris paribus* is the best.

Membranes of Bacteria in the Urethra. DR. J. JADASSOHN. (*Ibidem.*)

In three cases where the urine contained membranes which microscopically resembled those found in urethritis membranacea, the microscopical examination showed that the membranes consisted nearly exclusively of cultures of bacteria with very few epithelia and pus corpuscles. Clinically the cases did not show any inflammatory symptoms. The author does not consider the bacteria pathogenic.

Therapeutic Notes.

Calcium Chloride in Urticaria.—Wright (*Brit. Journ. of Derm.*, March, 1896) has treated two cases, one of them most persistent and distressing, by this method, with good results. The theory upon which administration of this drug is based is the diminished coagulability of the blood in urticaria, this defect being removable by the ingestion of the lime salt. It is given in large doses (thirty grains twice a day) in the beginning, reducing the dose later to ten or even five grains three times a day, as the symptoms lessen in severity. The amount given is increased with the occurrence of relapses. The second case showed urticarial outbreaks following injection of diphtheria antitoxine, the diminution of coagulability apparently produced thereby.

Treatment of Eczema.—Lassar (*Dermatol. Zeitschrift*, Bd. ii, Hft. 6, 1895) shows how favorable are the skin changes in eczema to the growth of saprophytic and pathogenic micro-organisms, and insists on minute attention being given to local factors in ætiology. He claims that the theory of internal irritation is the refuge of ignorance. Accordingly, his first step is local disinfection, best obtained by tar baths, taken after the tar has been painted on the surface. Afterward the surface is thickly dusted with Venetian talc. If the disease persists, Lassar thinks it due to the penetration into the lower lymph spaces of the original irritant. Thus he accounts for the efficacy of greasy applications in chronic eczemas, such as his own salicylic paste. Tar baths should be continued. In obstinate cases he recommends Wilkinson's ointment. If the Lassar paste sticks too closely, a mixture of zinc oxide, 60 parts, and olive oil, 40 parts, may be employed instead.

Prophylaxis of Iodic Eruptions.—Féré thinks these outbreaks may be prevented by careful antisepsis of the skin. He recommends baths, preferably of calcium permanganate. Baths with boric acid are too dear; with sublimate there is danger of intoxication; permanganate of potassium is objectionable on account of its coloring property.

Iodides, other than that of Potassium, in the Treatment of Syphilis. BRIQUET (*Journ. des mal. cut. et syph.*, p. 87, February, 1896).

The author's conclusions are these:

1. All the iodides have antisyphilitic properties.

2. Iodide of potassium is, generally speaking, the most active; iodide of rubidium, often better tolerated, seems to be almost its equal.

3. When iodide of potassium is not well borne, there need be no hesitancy in having recourse to iodide of sodium, which often acts well.

4. Iodide of strontium has no advantage over others.

5. Iodide of ammonium should be reserved for certain cases of grave syphilis if the potassium salt disagrees or is not active; it seems especially useful in tertiary eruptions.

6. Iodides of lithium and calcium act more slowly and less surely than those mentioned.

7. To secure an effect equal, or at least comparable, to that which iodide of potassium gives, all other iodides must be prescribed in the same doses.

Treatment of Chilblains.—De Montmollin (*Rev. méd. de la Suisse romande*, December 20, 1895) obtained prompt amelioration and an apparent cure in two weeks in two children by the following method: Baths of fifteen to thirty minutes' duration four times a day in a warm solution of tannic acid (1 to 100), and two baths of fifteen minutes in *eau de savon*.

Treatment of Acne of the Neck.—Brocq (*Jour. de méd. et chir. prat.*, 1895, art. 16,467) uses first a solution of resorcin, which is allowed to dry, leaving a powder behind. Later, he recommends ichthyol plaster, and when the acne has disappeared a five-per-cent plaster of chrysarobin.

Picric Acid in Scrotal Pruritus.—P. Bock (*La Clinique de Bruxelles*) has had success with picric acid in ointment (1 to 5 to 1,000) when other measures have failed. Owing to its toxic properties, it is well to begin with small amounts. He thinks it may be used, with care, in rebellious affections such as senile pruritus and prurigo ferox.

Treatment of Red Nose.—Lassar (*Derm. Zeitschrift*, 1895, t. ii, p. 489) recommends scarification after various methods of exfoliation have failed. Fifteen to twenty per cent resorcin paste is his favorite agent for producing the exfoliation. A superior method to scarification, since it leaves only fine scars, is acupuncture, done with forty points mounted on a solid disk one centimetre in diameter, which is worked by an electro-motor and stamping machine like that used in filling teeth. Thousands of pricks, very light and of desired depth, may be done in a few moments. Consecutive treatment is rarely necessary. In rhinophyma, which he regards as an adenocystic fibroma without epithelial proliferation, Lassar removes the hypertrophied tissue by ablation or decortication, covering the surface with Thiersch grafts, or leaving it under iodoform collodion, which in many cases serves as well.

Treatment of Syphilis.—Petrone (*Riforma Med.*, August, 1895), basing his experiments on the antiseptic effects of nitrites and theoretical considerations of the influence of mercury and syphilis on the economy, tried sodium nitrite in injections (5 to 50 centigr. a day) in two cases, one of secondary disease, the other of late hereditary syphilis, with disappearance of periostitis and gummata in thirty and twenty-six days respectively.

Piccardi (*Giorn. del. R. Accademia di Med. di Torino*, March, 1895) uses calomel traumaticin (one part to four) painted on the skin every two or three days. The method has an advantage over that of calomel injection, in that it may be stopped if accidents appear.

Richon inoculated a man who had had sexual relations with a woman undoubtedly syphilitic, mucous patches present on both labia, with serum from the blood of syphilitics. The last injections were from the blood of a patient whose disease was of eighteen months' standing, which seems to indicate that the previous ones were efficacious. The subject developed no syphilitic accident. (Quoted from *Annales de derm. et de syph.*, t. vii, No. 3, pp. 440 and 441). J. C. J.

JOURNAL OF
CUTANEOUS AND GENITO-URINARY
DISEASES.

Vol. XIV. AUGUST, 1896. No. 8.

Original Communications.

THE USE OF ARGONIN IN THE ACUTE STAGES OF GONORRHŒA: A PRELIMINARY REPORT.

By GEORGE KNOWLES SWINBURNE, M. D.,
Surgeon to Good Samaritan Dispensary; Instructor in Surgery, Post-Graduate Medical School.

THE introduction of a new drug for the treatment of this condition is sure to attract widespread attention and obtain extensive use, so that it will quickly take its place, when it is known how much or how little can be accomplished by its employment. The usually history of such drugs is that those who first use them are apt to have more favorable results than those who follow are able to obtain. The profession is apt to look with skepticism at the multiplicity of new drugs which, with their advertising literature, find their way to the office table, and a drug, to find its place, must fight its way or be consigned to oblivion, too often its only useful destination.

In some ways argonin promises to be an ideal preparation for the treatment of this condition. The first extensive study of its properties and use may be found in the excellent paper by Jadassohn in the Archiv für Dermatologie und Syphilis, 1895, page 179. This drug is a combination of silver with casein, and is a white powder, which, carefully heated with water over a water bath, forms an opalescent, viscid, albuminous fluid. The maximum strength of this solution is ten per cent; the reaction is neutral. Of the powder, fifteen parts contain as much silver as one part of silver nitrate. A peculiarity of this compound is that the silver is not precipitated by the addition of sodium chloride, nor is the compound decomposed by contact with albuminous substances. According to Jadassohn, it possesses powerful germicidal properties; it is not irritating to the mucous membrane of the urethra

even in the concentrated solution, nor is it escharotic; it possesses, however, no astringent properties. From experiments carried on in his laboratory, testing its powers of penetrating tissues, Jadassohn found it rather inferior to either the nitrate of silver or argentamine.

As the cases in which it was used by Jadassohn were either in the chronic stage or in the later acute stages, I resolved to try it as thoroughly as possible in the very earliest periods of the disease. It was not until the middle of March that this substance could be obtained in this country at all, and then only in such limited amount that extensive experimentation was out of the question. Since obtaining it I have used it in some fifty cases of acute gonorrhœa coming to me in the early stages of a first attack, and in about a dozen chronic cases which had proved rebellious to other modes of treatment. In the acute cases I have kept more or less careful notes, but the length of time that these cases have been under treatment and observation is entirely too short to form any intelligent judgment as to the ultimate value of this substance.

Desiring to use it in as many cases as possible, I was obliged to limit it to urethral injections with a simple urethral syringe. The method by urethral irrigations would mean the using of too much of the drug in a single treatment, and my supply would in consequence be rapidly exhausted; further, as this drug will probably be very expensive, its employment by irrigation in dispensary work will be necessarily very limited, valuable as that method has proved to be, unless it be found that a very weak solution by irrigation will accomplish as much as a concentrated solution by injection. Further, I was limited to a single daily injections, inasmuch as it is not practicable to give the patient the solution to use himself, as we can not be sure that it will be properly applied, and if a patient has his medicine, he will remain away and can not be properly supervised, so that no judgment can be formed as to the value of the drug.

I adopted then the following plan: The patient was examined, history taken, character of the discharge noted, a smear taken on a slide and stained, and the patient made to urinate in two glasses always; then the urethra was irrigated with a very weak (1 to 6,000) solution of permanganate of potassium: if the anterior urethra only was affected, then the anterior urethra only was irrigated; if the posterior urethra was also involved, intravesical irrigation from the meatus was practiced; then the patient was placed on the table and the anterior urethra slowly filled to distention, and the patient made to hold the lips of the meatus together for five to ten minutes. When posterior urethritis

was present, I slid a small soft-rubber catheter, about 15 F., which had been cut off so that it was only seven inches in length, down past the cut-off muscle and injected two drachms of the solution into the posterior urethra, withdrew the catheter, and filled the anterior urethra. The catheter was lubricated with the solution of argonin itself, which forms an excellent lubricant. I began cautiously with a two-per-cent solution, gradually increasing to the full strength (ten per cent), but after a few trials, finding that there was no inflammatory reaction, and no pain caused by the solution, I used the full strength in all cases. The patients came daily, except Sunday; a smear was taken on a glass slide and stained for gonococci, generally every other day, sometimes daily, and if the discharge disappeared, the shreds in the urine were collected on a slide and stained. No internal medication was given except for the regulation of the bowels. Of course, alcoholic beverages were cut off, but no special restriction of the diet was enforced, except that the patients were advised that milk and Selzer as a beverage was a good thing. Smoking was not prohibited.

In all the cases a rapid diminution in the discharge was noticed while they were under treatment, and in a majority of them there was noted a rapid diminution in the numbers of gonococci, and in several cases in which the presence of the gonococci was established at the first examination these were not found in the smear taken on the third day; but in several instances where the patient omitted treatment for a day or several days, there would be a slight increase in discharge and a reappearance or an increase in the gonococci. In some of these cases the germ would be rather persistent, sometimes increased in numbers; but in several instances, especially where treatment had been omitted, the renewal of treatment would quickly eliminate them again.

One of the most noticeable features was the absence of any inflammatory reaction following this method of treatment; on the contrary, the inflammation of the disease *per se* is markedly diminished from the very start; even in the earliest stages, the ardor urinæ is markedly diminished, in most cases completely so. Chordee was twice complained of, but inquiry as to what the patients understood by chordee established that they suffered from simple erections, which naturally were somewhat painful. The treatment itself caused absolutely no pain in any case, and frequent inquiry as to the effect of the injection elicited the answer that "there was a little burning for a while, but that was all."

In one case treatment was changed to irrigation with hot permanganate solution because the patient imagined that the argonin gave him a headache and requested to have it omitted. In his case, a boy

seventeen years old, it is to be noted that he had been irrigated for a few days before the argonin was begun, and that shortly after the argonin was begun his headaches came on in the afternoon, two or three hours after, and this symptom was not complained of after the argonin was omitted. There may have been something in this, for several of the cases suffered for several days from persistent headache, sufficiently to call for medicinal treatment for this condition, which seemed to be associated with persistent constipation. Whether this was in any way due to the argonin I am not prepared to say, but the constipation was unusually difficult to overcome, and I find I have prescribed more laxatives than I am ordinarily in the habit of doing. I found the fluid extract of cascara to work well in the majority of cases. Outside of this there were no unpleasant effects which I have to ascribe to the drug. It, however, does stain the linen or clothes and the hands as badly as does the nitrate of silver, but care in this direction will obviate this, and cyanide of potassium readily removes stains from the fingers and finger nails and clothing.

The cases selected for the treatment were taken from a very large number, and with two exceptions only those coming with their first attack were selected, and of these, only those presenting acute symptoms and coming within the first two weeks of their attack were so treated. There were, however, three cases presenting severe symptoms which were three weeks old.

My reasons for selecting cases coming with their first attack of gonorrhœa are—

1. Because in the great majority the urethræ of these cases react differently to irritants of any kind than do urethræ which have already passed through one or more attacks.

2. Unless we know pretty well the previous history of a urethra which has passed through a previous attack, how do we know that we are treating a new, fresh attack of gonorrhœa and not an old, reawakened one? Too many have scored successes with instances of this class only to meet dismal failure with cases with their first attack. In illustration of these two facts I have careful notes on eight cases of acute gonorrhœa which came to me within forty-eight hours of the first appearance of trouble, on which I tried a method as detailed and recommended by Dr. Lyons in the Medical Record for May 4, 1895, namely, the injection of nitrate of silver in strength of four per cent. Four of these cases had never before had gonorrhœa and four had suffered from previous attacks. In the first four cases the result was prolonged treatment covering a much longer time than is usually considered neces-

sary. One developed epididymitis, one developed stricture, one after two months' treatment left town uncured, and one left early, but not until I was satisfied that the treatment was a failure. All these cases did well at first. In the other four cases, there was an absolute cutting short of the process with disappearance of gonococci within three days, as brilliant a success in each case as any of those so well pictured by Dr. Lyons. Therefore, if a drug or a method is to be really of value for this condition, we must be able to show either that by its use the average length of time is shortened, or that a patient is carried through an attack with greater comfort, less liability to complications, and less liability to chronicity than by other methods in use. And I believe that cases with their first attack present the best field for a careful study.

Of cases coming with a first attack and treated by this method there were fifty-one. In three of these only, the presence of the gonococcus was not established, and in two cases with a second attack; eight disappeared after receiving one treatment and ten left too early in their treatment to enable me to form any judgment as to the probable outcome. Leaving out the eight cases that disappeared, of the remainder there came the first day the discharge was noticed, 12; within forty-eight hours, 8; within three days, 2; within four days, 5; at end of first week, 9; in two weeks, 6; in three weeks, 3—total, 45.

Of these cases, 8 had posterior urethritis when they came, 8 developed posterior urethritis while under treatment, 13 did not develop posterior urethritis, 10 did not develop posterior urethritis, but left too soon to know what might be the final outcome; 6 have not developed posterior urethritis, but are still under observation—total, 45.

One of these cases, whose history is given below, developed epididymitis.

History of the Two Cases having had a Previous Attack.—Case 2232 was treated by me a year ago for his first attack. He presented himself on the fourth day of the discharge, eight days after exposure; incubation, four days; purulent discharge. Smear revealed a few gonococci. Urinating in two glasses, the first was cloudy, the second clear. Received ten-per-cent argonin injection. The second day, less discharge; received ten per cent argonin. The third day, very slight discharge; no gonococci found; argonin, ten per cent. The fourth day, no discharge; first glass cloudy, second clear; argonin, ten per cent. The fifth day, no discharge; both glasses clear; floating shred in first glass, no gonococci; argonin, ten per cent. He came again on twelfth day; condition as on fifth day; argonin, ten per cent. On the

eighteenth day he again came; both glasses clear; no treatment. He appeared one month later; both glasses clear; prostate not examined.

Case 2467, second attack. First attack two years ago; discharge had lasted two days; incubation, five days; purulent discharge; stained; numerous gonococci; first glass cloudy, second glass clear; argonin, ten-per-cent injection. The second day, less discharge; both glasses clear, shreds in one; argonin, ten per cent. The third day, same as yesterday; stained; gonococci present, but fewer in number; argonin, ten per cent. The fourth day, same; argonin, ten per cent. The fifth day, discharge reduced to a minute drop; stained; a very few gonococci found; argonin, ten per cent. The seventh day, no discharge; shreds in first glass; both glasses clear; argonin, ten per cent. The eighth day, same. The ninth day, very thin discharge; stained; a very few gonococci; argonin, ten per cent. The tenth day, no discharge; same. The eleventh day, same. The thirteenth day, very slight discharge; both glasses clear, first contains shreds. The sixteenth day, omitted treatment three days; very slight discharge; a few gonococci found; argonin, ten per cent. The seventeenth day, no discharge; both glasses clear; argonin, five per cent. The eighteenth day, slight discharge; argonin, ten per cent. The nineteenth day, same. The twenty-first day, same; first glass slightly cloudy. The twenty-third and twenty-fourth days, same. The twenty-fifth day, no discharge; argonin, ten per cent. The twenty-seventh day, same. The twenty-eighth day, no discharge; shred in first glass, second clear. The thirtieth day, slight discharge; a few gonococci. He came on the thirty-first, thirty-second, thirty-fifth, and thirty-eighth days. On that day there was no discharge; floating shred in first glass, second glass clear; has not returned.

Of the cases coming with a first attack I give three, which were remarkable:

Case 3457, first attack; discharge first noticed that morning; exposure three days ago; very slight, thin discharge; stained; epithelial cells, pus cells, containing gonococci, and gonococci outside free; both glasses clear; first contained one shred, which sank; argonin, ten per cent. The second day, no discharge; shred in first glass; arogonin, ten per cent. The third day, came without having passed the night urine; no discharge; one shred in first glass; stained; no gonococci; epithelial cells; argonin, ten per cent. The fourth day, same as yesterday. The fifth day, no discharge; patient notes watery discharge in rising in morning; urine held six hours; one shred in first glass which floated, then slowly sank; stained; contained pus, epithelial cells; no

gonococci; argonin, ten per cent. The sixth day, no discharge; urine held six hours; one floating shred in first glass; no treatment. The seventh day, same ; no treatment; still under observation. This case I regard as cured at the first injection.

Case 2829. First attack; discharge has lasted twenty-four hours; exposure seven days previously; purulent discharge; stained; gonococci found present; both glasses clear; shreds in first; argonin, five per cent. The second day, very slight discharge; stained; a very few gonococci found; both glasses clear, shreds in first; argonin, ten per cent. The third day, discharge thin and watery, and very slight moisture of meatus; urine in glasses as yesterday; argonin, ten per cent. The fourth day, no discharge; lips of meatus slightly glued; argonin, ten per cent. The fifth day, same; moisture from meatus in slide; stained; epithelial cells; extracellular gonococci; argonin, ten per cent. The sixth day, no discharge; shred in first glass, second clear; argonin, ten per cent. The eighth day, same; argonin, ten per cent. The ninth day, stained; epithelial cells only; argonin, ten per cent. The tenth day, stained; same as ninth day. The eleventh day, lips glued; one floating shred in one glass; both glasses clear; argonin, ten per cent. The twelfth day, up late last night; watery discharge; stained; epithelial cells; no gonococci; argonin, ten per cent. The fifteenth, sixteenth, and seventeenth days no discharge; shred in first glass; stained; epithelial cells; no gonococci; argonin, ten per cent. The nineteenth day, long bicycle ride yesterday; slight watery discharge; stained; no gonococci; epithelial cells; first glass, floating shred, second clear. Returned on twenty-sixth day; had been drinking beer, and had coitus twice; no discharge; both glasses clear; a faint floating shred in first glass. This case, I believe, was cured by third injection.

Case 2405. First attack; discharge has existed six days; incubation, seven days; purulent discharge; stained; but slide was misplaced, and therefore unfortunately not stained; first glass cloudy, second clear; argonin, ten per cent. The second day, less discharge; stained; pus cells; no gonococci could be found after a careful search; first glass slightly cloudy, second clear; argonin, ten per cent. The third day, no discharge; first glass cloudy, second clear; argonin, ten per cent. The fourth day, no discharge; both glasses clear, floating shred in first glass; argonin, ten per cent. The fifth and sixth days, same; returned on tenth, eleventh, and twelfth days, same; returned on eighteenth day, there was a slight discharge; had emission the night before; stained; no gonococci found. The nineteenth, twentieth, and twenty-

first days, no discharge; both glasses clear, floating shred in first; argonin, ten per cent. Seen on twenty-eighth day, condition same; no treatment. In this case it is a pity that the first staining was lost; the probability is, however, that it was a case of simple, nonspecific urethritis, in spite of the long period of incubation, about which I made careful inquiry.

Case 1805. First attack; discharge twenty-four hours; incubation, ten days; purulent discharge; stained; epithelial cells, pus cells, gonococci, intracellular but not numerous; argonin, two and a half per cent. The second day, very slight discharge; argonin, five per cent. The third day, very slight discharge; both glasses clear; argonin, ten per cent. The fourth day, no discharge; both clear; argonin, ten per cent. The fifth day, same. The seventh day, same. The eighth day, same. The fourteenth day, both clear; no discharge; argonin, ten per cent. The fifteenth day, same. The eighteenth day, same. Returned on twenty-fifth day with discharge; his brother, who brought him to me, told me that he had not been behaving properly, but had repeatedly indulged in coitus. I refused to give argonin any longer; patient became irregular, coming once or twice a week; the discharge, always slight, persisted, and posterior urethritis came on; was severe for two or three days; and patient began to come more regularly, but I only irrigate him with permanganate of potassium. Is doing well, though he has several times drunk beer. As he is no longer under argonin, the case is of no further interest, except that he was doing well and was a good illustration of the value of argonin.

Case 2270 presents a severer type of the disease. First attack; discharge for seven days; incubation, five days. Has been treated by a doctor who gave him santal-Midi capsules in large amount; patient sick; entire penis swollen and œdematous; lips of meatus œdematous, narrowing it; purulent discharge; stained; numerous gonococci; patient in constant pain; urinates frequently, and gets up every fifteen minutes at night to urinate; the act is so painful that patient dreads it; first glass cloudy, second clear; irrigated anterior urethra with 1-to-6,000 hot permanganate; painful at first, but rather grateful as irrigation is persisted in; argonin, five per cent. The entire penis is wrapped with a wet 1-to-1,000 biehloride dressing and protective tissue, and patient instructed to keep it wet. Calomel, ten-grain powder with sod. bicarb., to be taken at night. The second day, œdema much less; patient more comfortable, greatly pleased; second glass clear; argonin, five per cent, after hot 1-to-6,000 permanganate douche; wet bichloride as before. The third day, marked improvement; second glass clear;

argonin, ten per cent. The œdema disappeared completely by the fifth day; discharge steadily lessened, in fact was always slight after the fourth day. This patient continued his work, which was that of cutter, and when he began to be better, he was put to work on a patent arrangement for cutting through many thicknesses of cloth; he had to sit on a seat like a bicycle seat and work both feet and hands; the discharge continued slight; always contained a few gonococci; on the twentieth day posterior urethritis began, and ten per cent argonin was injected into deep urethra; discharge ceased on twenty-second day. On the twenty-seventh day it returned; stained; no gonococci; both glasses still cloudy; gave up work because the bicycle seat was making him worse. The posterior urethritis began to diminish and ceased on the thirty-ninth day; when a day was omitted (as Sunday) a slight discharge would return, containing a very few gonococci. All symptoms have ceased for a week, but patient is still under observation; holds his urine two hours and a half; both glasses are absolutely clear.

Case 1977, a car conductor, came when discharge had lasted twenty-four hours; incubation, seven days; was followed twenty-eight days, and was apparently a perfectly uncomplicated case. Gonococci disappeared from discharge on fourth day and he was apparently cured by nineteenth day. There was only a slight mucous discharge at times and on the eleventh day. The sixteenth day, a very few gonococci were found. Case was progressing favorably; on the twenty-sixth day, a warm day, he had changed winter underwear to summer flannels; toward night it was cooler. The twenty-seventh day came with pain and swelling in right knee. The twenty-eighth day he could just get to dispensary; was advised to go to hospital. Patient is now at Mount Sinai; has been there two or three weeks. This was evidently a case of gonorrhœal rheumatism; his gonorrhœa had apparently been cured for several days, and I was keeping him under observation. After four weeks in the hospital he returned, stated that his discharge returned after he had been in the hospital three days; on his return he had no discharge, but had a subacute posterior urethritis. He was treated with deep argonin injections (ten per cent) for one week, and then returned to work.

Case 2518. Patient fifty-three years old, rather feeble and anæmic; the discharge (first attack) has existed forty-eight hours; incubation, four days; stained; gonococci found; first glass cloudy, second glass clear; argonin, two and a half per cent, injected. The second day, less discharge; first glass cloudy, second clear; argonin, five per cent.

The third day, a small drop of pus; stained; a very few gonococci found; first glass cloudy, second glass clear; argonin, ten per cent. The fourth day, still very slight discharge; patient doing well; argonin, ten per cent. The fifth day, no discharge; second glass a trifle cloudy; argonin, ten per cent, anteriorly. The sixth day, no discharge; second glass distinctly cloudy; argonin, ten per cent, both anteriorly and posteriorly. The eighth day, same. The ninth day, improving; second glass less cloudy; but this condition persisted till the twenty-first day, when patient began to have epididymitis. He is married and has continued to live with his wife, which I believe accounts for his condition. He came faithfully every day; the epididymitis lasted ten days and since then has continuously improved. To-day there is a very slight nodule in left epididymis. Treatment was not omitted for a single day during attack of epididymitis.

To-day, forty days since beginning of trouble, the posterior urethritis persists, but there is no urethral discharge; treatment was changed to bladder irrigation with 1-to-3,000 silver nitrate, and the case is making a steady improvement.

Case 2333. First attack, existed seven days; posterior urethritis from beginning; profuse purulent discharge; stained; numerous gonococci; by the eighth day discharge had ceased, but posterior urethritis persisted without improvement till the fifteenth day, then cleared in three days; patient then on twenty-fifth day, a few days after treatment was discontinued, returned with posterior urethritis, marked constipation and headache; this lasted till the twenty-ninth day and cleared again; returned on the thirty-second day, but cleared by thirty-fifth day. To-day he is still under observation, the forty-sixth day. There has been no recurrence. In this case patient's wife came over from Russia about the thirty-second day of his trouble and he had coitus with her, which I forbade, and for this reason I am trying to keep him under observation to see what the final outcome will be.

Case 2443 presents a moderately prolonged case. He is seventeen years old, and my experience has been that gonorrhœa at this age is often severe; discharge had existed forty-eight hours; incubation, six days; stained; gonococci found; first glass cloudy, second glass clear; argonin, two and a half per cent. The symptoms continued mild, but persistent; at no time did he suffer inconvenience; the discharge was always very slight, but did not disappear till the twenty-eighth day, and gonococci were found present one day after this. Posterior urethritis began on the tenth day of treatment, when the argonin was given by deep injection; it never caused symptoms, but was simply

noted by the fact that the second glass was cloudy. This cleared by the sixteenth day, but returned three days later and was the last symptom to disappear. All symptoms disappeared by the thirtieth day. This case is still under observation.

Case 1981 presents a case which was quickly overcome, but was prolonged from a malformed double meatus; at no time was posterior urethritis present and no discomfort. Case came on fourth day of discharge; incubation, nine days; gonococci present. By the sixth day all discharge had disappeared, both glasses were clear, and there was only a floating mucous shred in the first glass; patient was then absent three days; on his return there was a very slight discharge and a few gonococci found to be present, and first glass again slightly cloudy; the next day this had completely cleared, and on the fourteenth day a very slight moisture of meatus noted; stained, and no gonococci found. On the twenty-third day, after two days' absence, there was a minute drop of pus at the meatus; stained, and a few gonococci found present. This seemed to me to be due to the fact that there was a pocket close to the meatus from which this discharge was expressed. The next day a floating mucous shred in first glass only was noted. This condition continued for several days, only to be repeated after several days' absence. Endoscopic examination of urethra showed it to be in a healthy condition, but two infected urethral follicles were found just within meatus on each side. Then from the twenty-sixth day to the forty-fifth day the case was apparently cured; on the forty-sixth day the examination of a minute watery drop revealed a few gonococci, but there was no discharge. This is the condition to-day. By the sixth day the case was apparently cured. At no time since has there been any trouble—that is, severe symptoms; but a careful microscopic examination has revealed the presence of gonococci, which are persistent; hence a condition prevails by which an acute exacerbation may spring up at any time.

There are several cases which are somewhat like this last, in which there was rapid diminution of the discharge and gonococci, but which continued under treatment from four to six weeks. I can not help feeling that two injections a day would be well borne and very likely have had a good effect in these cases.

Cases 3280, 3297, 3299, 3358, 3365, 3407, 3409, 3450, 3467, 3540, 3618, and 3666 are still under observation, and are all doing remarkably well. In none of these cases are there severe symptoms or signs of acute inflammatory condition; none have developed posterior urethritis, and in none are there any signs of discharge from the time

of treatment until they appear the following day for treatment, when a slight amount of discharge is found to be present, and this is after they have held their urine three to six hours, as they are taught in all cases to do, in order that the bladder may contain enough urine for purposes of examination, and in order to form an intelligent opinion as to the amount of the discharge. These cases are still under treatment, and will form a good study as to the final outcome; they all came early in the trouble and are faithful in attendance. Of these cases—

Case 3358 is typical. Came on first day of discharge; incubation, five days. All the typical signs of a beginning acute gonorrhœa; has been under treatment daily for two weeks; at no time has there been more than a thin drop of pus at meatus just before treatment, nor does there exist any discharge at any other time of day; has had absolutely no discomfort at any time; daily examination of this pus shows the presence of gonococci. For several days has come holding the night's urine in the bladder; both glasses are clear; the first contains one or two shreds which sink slowly; in the beginning gonococci were numerous and easily found; latterly they are found only after considerable search. The last note, on thirteenth day, patient came, having held urine twelve hours; only a thin, minute, opalescent drop of pus could be noted; stained, and one or two cells in the microscopic field were found, after considerable search, containing typical gonococci.

The three cases which came in the third week all had posterior urethritis and considerable purulent discharge—2936, 3328, and 3530.

Case 2936 was under treatment twenty-eight days; his case was prolonged by an abscess of the frenum, communicating with the floor of the urethra. This was destroyed by the injection of two or three drops of ninety-five-per-cent carbolic. The case is to-day clear, having been one week without treatment.

Case 3328 had slight posterior urethritis and considerable purulent discharge. No posterior urethritis after three days. A slight watery discharge on coming in the morning No gonococci found after he had been under treatment one week.

Case 3530 had posterior urethritis and purulent discharge containing gonococci. On second day there was no evidence of posterior urethritis, and on the third day no discharge; has remained clear for four days; still under treatment.

I have used argonin in about a dozen cases of chronic urethritis which were rebellious to other modes of treatment, and have been impressed with the results.

My impressions regarding this drug are that its use is absolutely harmless; that it shows marked power in causing the disappearance of the gonococcus; that it has peculiar power in allaying the inflammation of the disease, and I am strongly impressed by the degree of comfort that the patients possess even in the most acute stage. The only observations which I have not yet been able to make, on account of the shortness of time the drug has been in use, is the liability of these cases to relapses, and of this a further study must be made. Naturally, if the gonococci are all removed there will be no tendency to relapse.

Jadassohn seemed to think that by the addition of 0.3 per cent liquor ammoniæ caustici he obtained greater power of penetration in chronic cases.

In forming a judgment of the value of the treatment in these cases it is to be borne in mind that they received only one injection a day, and none on Sunday; that as a rule they have to work hard to maintain themselves, and that many are machine operatives, probably the worst trade they could follow as regards this disease, and many lose their dinner hour in order to receive treatment.

48 East Twenty-sixth Street.

A PECULIAR DISEASE OF THE SKIN, ACCOMPANIED BY EXTENSIVE WARTY GROWTHS AND SEVERE ITCHING.

By WILLIAM THOMAS CORLETT, M. D., L. R. C. P. Lond.,

Professor of Skin and Venereal Diseases in the Medical School of the Western Reserve University, Dermatologist to Charity Hospital, and Consulting Physician for Skin and Venereal Diseases in the City Hospital, Cleveland.

IN the British Journal of Dermatology, June, 1896, Mr. J. Numa Rat, of St. Kitt's, reports a case of "coolie itch," with photographic illustrations of the disease. From the cut and description given, I was forcibly reminded of a case that presented itself some years ago, the history of which may be given as follows:

C. W., male, aged fifty-two years, complained of a dry, papular eruption on the outer surface of the legs, accompanied by severe itching. The patient further said he had always been troubled more or less with an itchy skin, generally worse in the winter, although at no season of the year was it entirely absent. In February, 1888, four months before the patient came under observation, there appeared in

the middle third, external surface of the legs, reddish papules, slightly scaly, and accompanied by severe paroxysms of itching. The papules extended at the periphery until they attained a size varying from that of a split pea to a half-dollar. Their outline was roundish or oval, or, after coalescing, irregular in shape, elevated distinctly above the surrounding skin, with a papular, slightly scaly surface, resembling flat,



warty growths. No moisture was present, but after vigorous scratching a small quantity of blood oozed from the surface.

The veins of the legs were not enlarged, although the eruption at the base presented a bluish or violaceous tint, which made one think of angiokeratoma as described by Mibelli,* Dubreuilh,† Windham

* Mibelli. Giorn. Ital. d. Malatt. Ven. e d. pelle. Fasc. iii, Sett., 1889.

† Dubreuilh. Ann. de la polycl. de Bordeaux, Janvier, 1889.

Cottle,* and Zeisler.† There was, however, no cavernous dilatation of the blood-vessels apparent.

During certain stages of development it looked not unlike lichen planus. In the course of a few months (July, 1888) the disease had extended, so that a few small papules were found on the thighs, arms, and trunk. These were sparsely distributed, smaller, being lentil-sized, and of a brighter color and very itchy. Aside from the subjective symptoms already given, the patient complained of a "tired feeling in the legs" with a slight "feeling of numbness in the feet." The tendon reflex at the knee was nearly absent. At this time the accompanying photograph was taken. (See cut.)

Galvanism and various other methods of treatment were employed, without apparently influencing the course of the disease.

In the autumn of the same year (November 17, 1888) my notes show that there was a slight diminution in the papillary growths; the itching was somewhat less severe, appearing at intervals of two or three days. The patient claimed that his feet were swollen, so that a change of boots was necessary, although no enlargement could be detected by the eye. He also complained of a pricking, benumbed feeling in the soles and palms; he believed he could not tell whether or not his feet were wet, and was afraid they might become frostbitten during the winter without his knowledge.

He could walk in the dark without difficulty, knew the location of his feet, and could touch the point of his nose with his eyes closed. On examination, the sensation was found to vary in different parts; thus on the ball at the base of the great toe a pin was thrust into the skin for a short distance with but slight pain, while the sensation in the sole at the arch of the foot was increased. At the ball he could not distinguish between one and two pins nearer than half an inch, while on the leg they could not be distinguished nearer than an inch apart.

At this time the lower region of the spine was blistered, under which the numbness was less complained of, and finally it was noticed only in the toes.

During the winter under a tonic treatment, which consisted of the mineral acids, nux vomica, and the zinc phosphide, his general condition improved, and his weight increased twenty pounds. Locally, resorcin, carbolic acid, and salicylic acid, in various vehicles, seemed best to meet the indications, and finally in June, 1889, one year after the patient was first seen, my notes show that the verrucous plateaus

* Cottle. St. George's Hospital Reports, vol. ix, 1877–'78.

† Zeisler. Trans. Am. Dermat. Association, 1893.

had well-nigh subsided, had lost their papillary appearance, were slightly scaly, and assumed a dark-brownish color, resembling very closely the cut of Mr. Numa Rat's case.

From this time the patient was only seen at longer intervals, the eruption gradually subsided, the pigmentation was absorbed, and at the present time the subjective symptoms, aside from the occasional pruritus, are no longer complained of.

This case I believe of interest, because of its unique appearance and the peculiar neurotic symptoms complained of. In spite of Unna's view, one might be inclined to the opinion that the papillary hypertrophy following and associated with disturbances of sensation were the result of the latter. Again, as the patient had always had an itchy skin, the act of scratching which preceded the papillary hypertrophy might be served as a means of inoculating micro-organisms which, according to Kühnemann* and others, are found in verrucous growths of the skin.

Of the extensive warty growths reported, notably those of Thin,† Tenneson and Besnier,‡ and Géury,# the accompanying symptoms complained of in this case were absent. Again Mr. Numa Rat's description presents such a close similarity, that it occurred to me they might be of a like nature. Without questioning the position taken by this writer, that "coolie itch" is a disease *sui generis*, yet my own experience in investigating the so-called "prairie itch," "miner's itch," "lumberman's itch," and "Scioto scratches," of our own country, published some years ago,‖ and more recent observation of various cutaneous diseases within the tropics, inclines me to the belief that we should accept with caution many of the so-called race and topographic diseases of the skin, for with few exceptions their counterparts may be seen among the inhabitants of the north temperate zone.

553 Euclid Avenue.

* Kühnemann. Monatshefte f. prakt. Dermatol., i, viii, No. 8.

† Thin. Med.-Chir. Transact., vol. lxiv, London, 1881.

‡ Tenneson and Besnier. Ann. dermat., 2e, t. x, 1889, pp. 22, 200.

Géury. Ann. dermat., 2e, t. x, 1889, p. 92.

‖ A Clinical Study of the So-called Prairie Itch, Lumberman's Itch, etc. Jour. Am. Med. Association, October 13, 1888.

COMPLETE EXTIRPATION OF THE PENIS FOR EPITHELIAL CARCINOMA.

By ORVILLE HORWITZ, B. S., M. D.,

Clinical Professor of Genito-Urinary Diseases, Jefferson Medical College; Surgeon to the Philadelphia Hospital; Consulting Surgeon to the State Hospital for the Insane.

EPITHELIAL carcinoma of the penis, though rarely encountered, is one of the gravest diseases that can attack that organ.

It usually begins on the glans or prepuce; later both structures become involved. As a rule its appearance is as a warty excrescence; in some instances it is soft, but more commonly it is hard and dry. It may be single, multiple, sessile, or pedunculated. The base is fixed and indurated; later on becoming cracked, fissured, and the seat of ulceration; thus differing from the benign venereal wart.

Epithelial carcinoma may have its origin as an ordinary persistent pimple, which is dangerous from being, as a rule, deeply seated in the neighborhood of the lymphatics; it is early followed by involvement of the secondary glands. Later it breaks down and becomes a chronic ulcer.

Individuals who have passed middle life, who have a long foreskin and suffer from chronic balanitis are most liable to carcinoma. Its first appearance is as a raw patch, which, not yielding to treatment, gradually becomes covered with a crust under which the ulcerating process goes on. A few cases are reported where cancer made its appearance in the urethra; and it has sometimes followed chancre or chancroid occurring later in life. In rare instances it has been developed from an infected wound, and in persons subject to constant irritation of the glans penis due to a tight or adherent foreskin.

The case which I wish to report is that of an individual sixty-one years of age, by occupation a laborer, with a negative family history.

It appears that his general health was good up to August, 1895, when he suffered from an attack of balanitis, to which affection he had long been subject, his foreskin being long and redundant.

The inflammation of the glans was persistent and did not yield to treatment. A raw surface about the size of a ten-cent piece made its appearance on the center and posterior portion of the glans, which was the seat of intolerable itching, making constant scratching an absolute necessity. The irritation of the finger nails produced

swelling, and ultimately ulceration of the part, slowly extending and at the same time surrounded by large exuberant warts, accompanied by a bloody discharge.

This person presented himself at the genito-urinary department of



FIG. 1.—Carcinoma of the Penis before Operation.

Jefferson Hospital in October last, when an amputation back of the corona glandis was advised, but to this treatment he refused to submit and left the institution. He returned on the 27th of April, and requested that the operation be performed. On examination the penis was found to be enormously enlarged, measuring, throughout its length, seven inches in circumference, with deep, foul-smelling ulcerations around the penile portion of the member (Fig. 1). There was great difficulty in passing his urine, and there were lancinating pains extending to the perineum. Phimosis was complete.

The patient had lost a great deal of flesh since last seen, and he was altogether below par.

It was decided that complete extirpation of the organ, after the manner recommended by Mr. Pearce Gould, was the only remedy. It was determined to leave the extirpation of the glands of the groin for a future operation.

The patient was etherized and the skin split on the dorsum of the penis, in order to expose the glans and enable me, if possible, to pass a catheter into the urethra; but I was unable to discover the outlet, immeshed as it was among the warty mass which surrounded the glans. He was placed in a lithotomy position, and the scrotum split from

the root of the penis to the perineum along the raphe; the corpus spongiosum was then exposed and carefully separated from the corpora cavernosa, and dissected back as far as the triangular ligament. The urethra was now cut across and isolated until a sufficient length was assured to enable me to fasten it to the perineum, when the incision was carried around the root of the penis. The suspensory ligament was divided and the corpora cavernosa were detached in like manner, until the crura alone remained on each side, which were then cut through by means of a raspatory. Some little difficulty was experienced in controlling hæmorrhage from the crura on the right side, and it became necessary to retain two hæmostatic forceps *in situ* for forty-eight hours.

The urethra was stitched to the perineum, the wound irrigated, a drainage tube inserted, a catheter passed on to the bladder, and the parts approximated by means of silkworm-gut sutures.

The patient made an uninterrupted recovery (Fig. 2). It was found on examination that the enlarged glands of the groin had resumed their natural size and required no further attention.

When carcinoma involves the glans only, amputation directly back of the corona will be found sufficient. In two cases of the kind in which I performed the operation, one dating back two years and the other nine months, not only has there been no return of the disease,



Fig. 2 —Carcinoma of the Penis after Operation.

but the individuals have been enabled to indulge in the act of coition without apparently missing the absent glans.

When the body of the penis is involved, and amputation becomes necessary, and the resulting stump is too short to permit of sexual inter-

course, it is in my opinion safer, and accompanied with less risk, to perform a complete extirpation instead of operating in the neighborhood of the peno-scrotal junction.

In cases where carcinoma originates in the urethra a complete extirpation is the safest procedure, as they are more likely to be followed by secondary involvement than when the disease has its beginning in some other portion of the organ. After the patient has convalesced he should be instructed to daily insert a meatus bougie into the urethral opening, which will prevent a contraction of the orifice, to which there is always a tendency.

REPORT OF A CASE OF REINFECTION OF SYPHILIS.*

BY HOWARD PAXTON COLLINGS, B. S., M. D.,
Hot Springs, Ark.

IN consideration of the fact that there are so few authentic cases of reinfection of syphilis on record, and that so many of the great syphilographers of this country and abroad say in their writings that they have never seen such a case, I feel justified in placing this one on record.

The patient, Fred C., aged twenty-eight years, single, a miner by occupation, came to me a year ago and gave a history then of having had a chancre eight years previous, followed by secondary manifestations. The resultant scar of the chancre is located on the dorsal surface of the penis to the right of the median line, and about one half inch from the corona glandis. The patient is a very intelligent man, and gives a perfectly clear history. The chancre appeared twenty-one days after intercourse, and this in turn was followed by a roseolar rash over the body, alopecia, and mucous patches in the mouth and throat. In all, his treatment extended over two years, during which time he made two trips to the Springs, taking a thorough mercurial course, in conjunction with the baths and under the direction of competent physicians whom you all know. During the first eighteen months of the disease he had mucous patches in his mouth and throat a good part of the time.

After the lapse of two years from the appearance of the chancre

* Reported to the Hot Springs Medical Society, January 7, 1896, with exhibition of patient.

he went west to the Pacific slope, and for six years he remained absolutely free from any syphilitic manifestation. When I saw him a year ago he had some rheumatic pains, which I thought due to his occupation—mining—and prescribed for him accordingly, with relief. I could then find no evidence of syphilis whatever.

He came to my office again the second of last month and gave the following history: About August 1st last, nearly nine years after the first chancre and twenty-eight days after exposure, there appeared a chancre on the dorsal surface of the penis one half inch from the corona, to the left of the median line, the scar of which can be plainly seen and felt now. Six weeks from the appearance of the sore mucous patches developed about the anus, to which he applied various salves without relief. Two weeks later, or about two months after the appearance of the chancre, an eruption appeared on the scalp. These spots were present when I saw him, and were as large as a one-cent piece and moist. At the end of the tenth week a mucous patch developed on the under surface of the tongue to the left of the frenum. This has disappeared under treatment, but there is now one plainly seen on the tip of the tongue. Toward the close of the thirteenth week there developed two spots on the left calf and one over the right gluteal region. These were as large as a silver twenty-five-cent piece, dark, excoriated, and moist, and, while they are now healed perfectly, they are still considerably pigmented.

When I saw him at the beginning of the seventeenth week of the disease, the epitrochlear glands, the suboccipital, and those in the inguinal region were markedly enlarged.

This I believe to be a true case of reinfection of syphilis, and, although we all see a great number of syphilitic patients here, this is the only one I have seen which has shown positive evidences to me of a reinfection.

2241 *Central Avenue.*

DEGENERATION OF TESTICLE FOLLOWING AN INJURY; OPERATION; RECOVERY.*

By I. N. BLOOM, A. B., M. D.,

Clinical Professor of Genito-Urinary Diseases in the University of Louisville; Dermatologist to the Louisville City Hospital, etc., Louisville, Ky.

THE specimen which I present for your examination is a testicle removed from a patient, thirty-seven years of age, who sixteen years ago, in jumping on a horse, injured both his testicles, followed by acute orchitis and acute epididymitis, during which time the man received no treatment. Following this injury a hydrocele developed on each side; the one on the right side was tapped four years later and injected with some fluid the nature of which the patient does not know, which was followed by a complete cure, leaving a slightly enlarged testicle and a slightly enlarged epididymitis on the right side. The left side was never operated upon until the gentleman came to my clinic at the University of Louisville four weeks ago.

Upon examination I found an enormously distended scrotum which was pyriform and lobulated in shape, a left-sided hydrocele with an elongated condition at the lower extremity. A trocar was inserted and one pint and a half of clear serous fluid withdrawn; the enlarged testicle could then be plainly felt in the scrotum, but the hydrocele did not entirely disappear, fluid being evident in the lower portion of the sac after aspiration above. I introduced the trocar at the dependent portion of the scrotum and from a pocket there drew off another ounce of fluid. At the end of a week, there was a reaccumulation of fluid; the scrotum was again aspirated and about three ounces of serum withdrawn, and this time injected with a mixture of one drachm each of carbolic acid and tincture of iodine. Reaction was comparatively slight as far as pain was concerned, but fever developed, temperature at first varying from 101° F. in the morning to 102° F. in the evening; on one occasion it went as high as 105° F., but as a rule the evening temperature was not higher than 103.75° F. Another unique feature about the case is that his pulse varied from 75 to 90, never going above 90. His condition to me seemed rather peculiar; I had hoped, however, that it was the reaction from the strong injection which I had given him. The testicle remained very

* Reported to the Louisville Clinical Society.

much enlarged, and evidences of disease were so plain that I decided to remove it, but the patient's condition was such that I delayed operation until last Friday, just two weeks after the injection.

Two weeks ago last Friday he was injected, and last Friday, two weeks having elapsed, I found the scrotum still very much enlarged and operated before the class, removing the testicle. A point to which I would call particular attention is the size of the testicle, being fully six inches in length by three inches in diameter at its widest point. When an incision was made through the skin a pocket of pus was encountered at the lower portion of the testicle corresponding to the point where a second aspiration was practiced. The operation was completed in a few minutes with comparative ease. It was not necessary to ligate the cord as a whole, I simply took it off high up; the spermatic and other arteries were ligated with silk; no other ligatures were necessary; hæmorrhage during the operation was practically nil. The external wound was closed without drainage. The patient went on the operating table with a temperature of 102.60° F.; immediately after the operation his temperature was 100° F.; Saturday evening temperature, 100° F.; Sunday morning temperature, 99° F.; Monday morning temperature, normal, and it has remained normal since. During the operation I did not open the tunic at all; it has been laid open since, and you will notice the testicular structure is practically gone, lying loosely in the cavity of the tunica vaginalis; the epididymis is atrophied and fibrous in structure; the tunic is enormously thickened as are also the scrotal walls, both having a leathery appearance. I will state that at the lower margin where the fluid existed there was an ulceration which has been vastly magnified by opening and handling since the operation.

The case is interesting on account of the rather unusual size of the testicle, with thickening of the parietal and visceral layers of the tunica vaginalis. The weight of this testicle was of course very great, and this feature caused considerable inconvenience in the sixteen years since the injury, and during which time nothing was done toward securing relief.

Dr. August Schachner: Two months ago I operated upon a man for a very large cystic tumor of the testicle. The history of the case was that the man up to that time had been a blacksmith, but since then has gone into the mercantile business; he had injured the testicle while shoeing a horse. At the time of the operation the scrotum was about the size of a child's head. The accident occurred five years before. While the outlines of the testicle could be distinctly made

out, still by compressing between the fingers it had the consistence of mush. The tunic was fully one fourth of an inch in thickness. The interesting feature about the case is that while the testicle had retained its shape for a numbr of years, still it was in a perfectly soft and rotten condition. There was no pus; the scrotum contained a greenish or blackish fluid.

Society Transactions.

AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

TENTH ANNUAL MEETING, HELD AT ATLANTIC CITY, N. J., JUNE 2 AND 3, 1896.

SECOND DAY, WEDNESDAY, JUNE 3D.

DR. CLAUDIUS H. MASTIN, *President, in the Chair.*

Operative Interference in Aggravated Instances of Seminal Vesiculitis.*—By DR. EUGENE FULLER, of New York.

DR. GEORGE CHISMORE, of San Francisco, said he fully agreed with the statement made by Dr. Fuller that, before undertaking any operation on the prostate or seminal vesicles, tuberculosis of that region should, if possible, be excluded. In one case of abscess of the seminal vesicles coming under his observation an incision was made through the rectum, resulting in a fistula which proved very annoying. Dr. Chismore said he had thus far never resorted to operative measures in the treatment of seminal vesiculitis; in a number of cases, however, he had seen marked benefit follow "stripping" the vesicle, after the manner suggested by Dr. Fuller.

DR. GARDNER ALLEN, of Boston, exhibited a specimen composed of inspissated mucus which was passed during urination, and probably had its origin in one of the seminal vesicles.

DR. JOHN P. BRYSON, of St. Louis, said he agreed with the statement made by Dr. Fuller that with the Zuckerkandl incision the field of operation was so limited that it was difficult to control the severe hæmorrhage which was apt to occur, while the rectum or bladder, or even the deep urethra, was very easily injured. In one case coming under his observation, in which the symptoms were very similar to those described by Dr. Fuller, the cause of the trouble was found to be a small calculus

* Will be published.

situated between the seminal vesicles and the prostate. It was nearly two months, in this case, before the patient reported any improvement whatever; since then he had progressed favorably.

Dr. J. William White, of Philadelphia, reported the following case: The patient was a man of some social prominence, who for years complained of certain symptoms after sexual intercourse, which had been usually attributed by those whom he had consulted to his imagination. The sensation consisted of an aching or throbbing, subacute in character, and referred to the rectum. There was no loss of power nor desire, but a slight tendency to premature ejaculation. An examination showed that the left seminal vesicle was distended and tender to the touch. The man was etherized and the vesicle stripped by means of a full-sized rectal bougie. At the next urination he passed several masses which looked like inspissated mucus, and a rectal examination on the following day disclosed the fact that the size of the vesicle had distinctly diminished. The patient's subjective symptoms also rapidly disappeared. The speaker said he has several cases of vesiculitis under his care at present which are tubercular in character, and in these he confined himself to hygienic treatment, which was probably all we can do for them.

Dr. A. T. Cabot, of Boston, said he was interested to learn how easily Dr. Fuller had been able to get at the seminal vesicles by means of the Kraske incision. The method of procedure advocated by the author of the paper in severe cases of seminal vesiculitis is certainly an admirable one.

Dr. Fuller, in closing the discussion, said he fully agreed with Dr. White that hygienic treatment was the only resort we have in cases of tubercular origin; by operating in such a case we are apt to light up latent foci there, and induce a rapid dissemination of the disease. In tuberculous cases the symptoms are not so acute as in the non-tubercular variety, and the patients complain comparatively little of pain. The speaker said he was inclined to think that calculi of the seminal vesicles occur more frequently than we suppose.

Renal Tuberculosis.—Dr. F. Tilden Brown, of New York, read a paper on this subject. He first discussed the question, How do the tubercle bacilli gain access to the kidney? We know of but three ways:

1. By the blood.

2. By their multiplication and the gradual development of tuberculous granulations along the ureter from the bladder—ascending urinary infection.

3. By an extension of the disease from a neighboring or remote organ.

Tubercle bacilli, to reach the kidney by the vascular channels, in the post-natal period, must ordinarily be taken up from the mucous or cutaneous surfaces by the lymphatics, advanced to the veins, then to the arteries, and by one of the renals brought to the kidneys and presented to a glomerulus for elimination. As to the ætiology of this vascular form

of tuberculosis, the necessity of the presence of the tubercle bacillus is recognized; but, in addition, a certain proportion of the cases present in their histories some distinct reference to a fall or blow involving the side or back. These stories make it reasonable to infer that a temporary congestion or otherwise insignificant trauma has been the determining factor in establishing the disease, just as so often occurs in a joint after injury, or in the lung after a pneumonia or an attack of measles.

Renal tuberculosis due to ascending urinary infection by continuity is a well-recognized process, although not as common as infection by the blood. The mucous membrane of the ureters apparently offers conditions very favorable to the life and dissemination of the bacilli. An existing vesical tuberculosis appears to have a natural tendency to reach out toward one or both ureteral openings, and from there to gain the pelvis of the kidney, the calices, the apices of the pyramids, and the medullary and cortical layers.

The third method of renal infection is that by extension to the renal parenchyma from a tuberculosis of another organ. The occurrence of this, natural as it may appear at first thought, is not well substantiated. The renal capsule seems to exert the same protecting influence against such tuberculous invasion as does the dura for the brain in tuberculous disease of the surrounding bone.

A summary of the different symptoms and evidences which have been advanced as in any way conducive to the diagnosis of renal tuberculosis, whether vascular or ascending in origin, will be fairly represented by the following: The existence of a tumor corresponding more or less accurately to the position of the kidney; such a tumor may or may not be painful to palpation, or it may be the seat of spontaneous pain, often intermittent; the tumor may be a center from which pains radiate to different parts of the abdomen, to the lumbar spine, down the groin, into the outer side of the thigh, or even into the opposite and healthy kidney. Again, without the presence of a tumor or an appreciable enlargement of the kidney, some of the following symptoms, which are mentioned in the order of their importance, may be noticed: Pallor and emaciation; œdema of the feet and legs; reaction to the injection of tuberculin; albuminuria; moderate pyrexia; night sweats; dysuria; pyuria, with acid urine; hæmaturia, with acid urine; polyuria; frequency of urination; turbid urine seen by the cystoscope issuing from a ureter; the finding of tubercle bacilli in that urine which is known to come from one or the other kidney, as when obtained by ureteral catheterization. The only micro-organism which can possibly lead us astray in microscopic diagnosis is the smegma bacillus. The morphology of this parasite, as well as its similar reaction to the ordinary staining method for tubercle bacillus, can when present easily be misleading unless generous alcoholic decolorization be employed.

The symptomatology of renal tuberculosis is very important, because

the physician who can make a positive diagnosis in a comparatively early stage of the disease renders more valuable service than does the surgeon who at a much later day performs a successful nephrectomy.

As regards the treatment of patients with renal tuberculosis, the rich will, as a rule, find their best resource in change of climate, careful attention to hygienic details, selected alimentation, and medicinal invigoration of the system. The poor, during the early stage of their disease, will receive the greatest benefit from a treatment which approximates as nearly as possible that advocated for their more fortunate fellow-sufferers. Even when the poor man has to gain a still poorer livelihood in some invigorating climate, he is apt to gain by the change a degree of health which the best medical and surgical treatment of the city would fail to effect. Theoretically, the earliest manifestation of a localized renal tuberculosis would be best treated by a radical surgical operation; but practical experience has pretty clearly shown that the temporary impairment of vitality attendant upon nephrectomy is of more disastrous import than is the presence of an early tuberculous lesion and the bacilli causing it. On the other hand, if this small, active tuberculous focus in the kidney is recognized comparatively early, it can by other than surgical measures, in many cases, be rendered so inactive as to approximate a cure. In exceptional cases, when the symptoms demand it, nephrectomy is not only legitimate, but strongly indicated.

Dr. Francis S. Watson, of Boston, referred to one point in the symptomatology of renal tuberculosis which he considered of some value —namely, the intermittence of the symptoms observed in many cases. The speaker said he had seen cases where there was marked irritability of the bladder, and yet there was no involvement of the lower urinary tract. Dr. Watson then referred to the value of resection or partial nephrectomy in some instances, and he reported a case in which he successfully removed the lower half of one kidney, which was involved by tuberculosis.

Dr. Fuller referred to the marked amount of sclerosis of the perirenal tissues one is apt to meet with in operating on these cases. In one case he cut through a mass of sclerosed tissue an inch and a half thick before he reached the kidney.

Dr. White, in speaking of the value of nephrotomy in cases where the tuberculous process involves the parenchyma of the kidney only, referred to three cases of this character in which he performed this operation during the past year; all of them recovered, two completely. As to the relative value of the lumbar and abdominal incision in nephrectomy, the speaker said that until last year he was a strong advocate of the former. He was induced to alter his opinion because the lumbar incision did not give the operator the necessary space. Even in cases of suppurative kidney it is perfectly possible to prevent infection of the peritoneal cavity by shutting it off properly and by employing adequate drainage.

The operation of partial resection suggested by Dr. Watson seemed to the speaker a very formidable one—more so than complete nephrectomy.

DR. CHISMORE said that for many years it had been his practice to abstain, as far as possible, from operative interference of any kind in cases of tuberculosis of the kidney, and this course had proved very gratifying. Dr. Brown, in his paper, spoke of resorting to catheterization of the ureter in order to discover the origin of the tubercle bacilli. Such a proeedure, Dr. Chismore said, or even the more simple one of cystoscopy, should be resorted to with considerable hesitation in any case where tuberculosis is suspected, as we are apt to aggravate the symptoms, perhaps converting simple frequent micturition into painful micturition, from which the patient will suffer during the remainder of his life. When we consider the fact that in many eases of renal tuberculosis the origin of the trouble was associated with traumatism, how much more likely it was that any trauma inflicted afterward will aggravate the condition and tend to disseminate the disease!

DR. JAMES BELL, of Montreal, referred to the importanee of determining the condition of the opposite kidney in eases of renal tuberculosis. In performing nephrectomy he preferred the abdominal operation, because it might throw some light on the condition of the opposite kidney, and also because it enabled one to secure the pediele with much more confidence than did the lumbar incision in ease the eicatricial condition of the perirenal tissues referred to by Dr. Fuller was present. In one case of tubereulosis of the kidney recently coming under his observation, where he intended to perform nephrectomy subsequently to a nephrotomy which had done no good, he desisted in the operation after an exploration of the opposite kidney, which was likewise found to be in an advaneed state of tuberculosis.

DR. BRYSON said he had come to the conclusion that there is no such thing as a symptomless renal tuberculosis. Before undertaking any operative measures in these cases we must bear in mind how frequently this condition is only a local manifestation of a general disease. In renal tuberculosis he had not found that increased nocturnal urination was a prominent symptom until late in the course of the disease, when the bladder or prostate became involved. The speaker said he agreed with Dr. Bell that one of the chief obstacles to surgical interference in these cases was the difficulty of aseertaining the exact state of the opposite kidney. With an advaneed tubereular lesion in one kidney we might have a cortieal lesion in the opposite organ, which might be fanned into activity by any operative measure. He agreed with Dr. White that complete nephrectomy is preferable to resection, as suggested by Dr. Watson.

DR. N. B. CARSON, of St. Louis, said we should be very careful indeed about interfering in localized tubercular troubles. He reported the following ease, which recently came under his observation: A young woman for many years had a localized tubercular trouble of one kn

joint. She entered a hospital, where the joint was opened and curetted; soon afterward it became necessary to amputate the leg above the knee, and about six weeks later the patient died, presumably from acute tuberculosis.

Dr. Brown, in closing the discussion, said he had never seen resection of the kidney performed, and would like to know more about it before expressing an opinion regarding it. He has never observed the thickened condition of the capsule referred to by Dr. Fuller in cases of renal tuberculosis. As to the location of the incision, the speaker expressed the opinion that if there were adhesions, the abdominal, intraperitoneal route was preferable. If there were no adhesions, he was inclined to favor the lumbar route. Local interference should only be undertaken in renal tuberculosis with the greatest care and where it was absolutely called for. He did not think that the abdominal incision could help us to any great extent to determine the condition of the opposite kidney.

Some Forms of Non-Obstructive Ischuria.—Dr. Alexander W. Stein, of New York, read a paper on this subject. He stated that inability to empty the bladder might be due to—

1. Atony of its muscular parietes. (a) Deficient contractile power of the so-called detrusor, from overstretching of its fibers; duration usually temporary. (b) Loss of power of detrusor, from atrophy and fatty metamorphosis; duration permanent.

2. Neurotic retention. (a) Deficient power of detrusor concomitant upon some psychic or functional disturbance of the nerve centers; duration temporary. (b) Paresis or cystoplegia, from organic derangement of the nerve centers; duration permanent (usually).

3. Spastic or reflex retention. Irritation from some neighboring organ; disappears with the cause that induces it.

The degree of atony resulting from overdistention of the bladder may vary from a slight and temporary impairment in the expulsive power of the organ to a complete and permanent inability to empty its contents, depending upon the age and health of the person, the condition of the bladder, the degree of distention, and the length of time the detrusor fibers have been upon the stretch. In the aged and feeble this condition was not uncommon, and permanent disability of the viscus often resulted from a single inattention to its behests. In the young and robust, atony was much less frequent, and the bladder, once relieved of its burden, regained its functional activity.

In some instances the bladder might be but slightly distended, and occasion more urgent symptoms than in another in which it had risen above the umbilicus; in the latter case the nerve-endings of the vesical neck (never very sensitive, perhaps) required only a slight cause, such free indulgence in spirits, etc., to obtund them still more. The expulsive factors, both muscular and nervous, were very feeble when com-

pared with the retentive factors, as only the latter are directly subject to sensation and volition. The frequency of micturition is not alone due to the quality of the urine, but depends in a large measure on the degree of tonic contraction existing in the vesical walls, which contraction is at first augmented as the muscular fibers are subjected to tension. The retentive and expulsive factors are so admirably adjusted one to the other as to bring about a harmonious sequence of action, and the feebly developed detrusor will gradually accommodate itself in power to any embarrassment to the escape of urine so long as the vesical neck retains its sensibility; but, as soon as this is lost, the fate of the patient is in most cases sealed. The thin, pale, flaccid, and insensible detrusor, associated as it often is with feeble health or exhausting disease, only requires to be once overstretched to become permanently atonied. If the muscular fibers have undergone no structural change other than overstretching, they will of course recover their tone more readily than when atrophic or fatty changes have involved their texture, and in such cases recovery is obviously not to be anticipated.

Dr. Stein then reported a number of cases of atony of the bladder coming under his observation.

DR. ALLEN said that some years ago he had a patient under his observation who was in the habit of urinating only once in twenty-four hours. In that case the bowels were also very sluggish.

Clinical and Pathological Observations on a Case of Castration for Prostatic Overgrowth.*

Prostatectomy on a Monorchid. With Microscopic Sections.†—By DR. JOHN P. BRYSON, of St. Louis.

DR. WHITE said the case reported by Dr. Bryson formed a valuable addition to the knowledge we were gradually acquiring as to the certainty or uncertainty of the result of double castration for enlarged prostate. When he introduced this operation he did so cautiously, and with the hope that it would not be indiscriminately performed. It was important that we report not only the fortunate but also the unfortunate cases. He had had one case in which death resulted from mania following the operation. We must study our cases carefully, and decide which were favorable for castration and which for prostatectomy. The speaker expressed the opinion that the operation of double castration for enlarged prostate had come to stay, and that there would always be cases suitable for it. In reply to a question, Dr. White said he was performing double castration in cases where the symptoms were urgent and the general condition of the patient good, while in cases which were practically hopeless, and also in those where the symptoms were not so urgent, but who had a strong sentimental objection to the loss of their testes, he performed ligation of the vas deferens or excised a portion of it.

* Will be published. † Will be published.

Dr. Cabot said that in the beginning, at least, the operation of double castration for prostatic overgrowth was performed too promiscuously, in spite of the fair manner in which Dr. White had presented the subject. It was very important that we should arrive, as soon as possible, at a clear understanding of the fact that the operation is not a trivial one, as we all at first believed. The speaker expressed the opinion that the mortality was due to the condition we have to deal with, and the question in a given case was, Which operation would relieve the condition with the least added danger, castration or prostatectomy? We know that we may have more trouble following the mere passage of a sound for a stricture of the urethra than from an extensive operation which entirely removes the obstruction. The drainage instituted after a prostatectomy immediately relieved the bladder and the kidney, while after castration the relief was more gradual. The kidneys might stand the strain or they might not, and this was probably the chief factor in the fatal cases that have occurred. Another factor was that the testicles no doubt exerted some tonic influence on the nervous system, and the cases of mania that have been reported following the removal of these organs were probably due to this fact.

Dr. Cabot reported two cases of enlarged prostate upon which he operated about a month ago. In the first case, he performed prostatectomy with a very satisfactory result. The second case was that of an old man who had a very peculiar prostate, which gave one the impression that if prostatectomy was performed it would leave an enormous wound in the vesical neck. The man was passing part of his urine per urethram; it was perfectly clear, and no instruments had been introduced. Castration was performed under cocaine. Subsequent to the operation he suffered from hallucinations, from which he gradually recovered. There was rapid shrinkage of the prostate, and his urination is less frequent and more comfortable.

Dr. Cabot expressed the opinion that shrinkage of the prostate after double castration was an established fact. It was difficult to understand what changes occurred in the organ, as the microscopical examinations thus far made have proved very unsatisfactory. Griffiths stated that the organ first passed through a glandular hypertrophic stage, then through a stage of glandular atrophy, which finally resulted in a fibrous prostate without much glandular tissue. If these changes do occur, how can we be certain that they did not antedate the castration? The speaker said he had examined two prostates removed post mortem—one from a man who had had double castration performed, the other not, and he could detect no special difference in the appearance of the two glands.

Dr. Fuller said it would be interesting to ascertain just what constitutes prostatic hypertrophy. He had often noticed that in some cases the prostatic overgrowth is enucleated very readily, while in others it was very difficult to remove it. If every one who performed these operations

or had the opportunity to do post-mortem work would have careful microscopic examinations made of the specimens removed, we might soon arrive at a definite conclusion as to what constitutes prostatic hypertrophy.

DR. BELL said that the more we discussed this subject the more clearly are we brought face to face with the fact that the immediate cause of death in all of these prostatic patients, no matter which operation is performed, is a form of toxæmia. The large number of cases of mania following castration that have been reported can hardly be classed as post-operative mania. No one can doubt that the operation of castration by itself ought to be absolutely without mortality. Prostatectomy, although a much more formidable operation, ought to be followed by a very small mortality. This toxæmia, which is probably responsible for the mental symptoms and the mortality, is something which we know very little about.

DR. CARSON reported two cases of prostatic hypertrophy coming under his observation. In the first case he performed prostatectomy six years ago, removing a considerable mass of prostatic tissue. The man was perfectly relieved until about a year ago, when he again found it necessary to resort to the catheter. He consulted another physician, who proposed double castration. As the patient would not consent to this, he resected about an inch of the vas on each side. This produced no appreciable change in the size of the prostate, but the patient was able to pass his water more comfortably; the improvement, however, was only temporary. The second case reported by Dr. Carson was one of cancer of the penis, where both testes were removed, together with the penis. At the time of the operation, it was found that one lobe of the prostate was slightly enlarged. The man was examined three months later, and at that time no appreciable change in the size of the organ could be detected.

DR. ABNER POST, of Boston, reported a case of prostatic hypertrophy recently coming under his observation where the patient developed certain mental symptoms, although no operation of any kind was performed. If castration had been performed in this case, the speaker said, the mania would no doubt have been credited to the operation.

DR. BRYSON, in closing the discussion, said he had always had the highest appreciation of the manner in which Dr. White put this operation before the profession. The speaker agreed with the statement made by Dr. Cabot that the histological investigations thus far made in connection with this subject have been very unsatisfactory. He was impressed, however, with the fact that all the prostatic tissue he removed, even though it appeared to be fibrous tissue, contained glandular elements. It seemed to him that the glandular tissue was the primary seat of the hypertrophy.

Duration of Acute Gonorrhœa.—Dr. H. M. Christian, of Philadelphia, read a paper on this subject. His conclusions were as follows:

1. Gonorrhœa is a more prolonged and serious disease than it is generally considered.

2. In two thirds of all uncomplicated cases, the period of time necessary to effect a cure is from six to ten weeks.

3. In that small proportion of cases where the entire urethra does not become involved, the disease being confined to the anterior urethra, we can expect a complete recovery in four weeks.

4. It is important to make an examination of the urethra before pronouncing a gonorrhœa as positively cured.

Dr. White referred to the impartial and scientific way in which this subject was treated by Dr. Christian in his paper, which he considered of distinct practical value.

Dr. Bryson said that Dr. Christian's conclusions were entirely in accord with his own ideas of the subject.

Dr. William Judkins, of Cincinnati, said that Dr. Christian's paper would prove of interest both to the specialist and the general practitioner. It was astonishing in how brief a period of time some physicians could cure gonorrhœa, judging by their own statements. He had heard of one man who claimed he cured the disease in ten days with bicarbonate of soda.

The following resolutions were unanimously adopted by the association:

Whereas, Certain attempts are being made to obtain legislation prohibiting vivisection in experimental pathology and physiology:

Resolved, That the American Association of Genito-Urinary Surgeons hereby places itself on record as pronouncing such efforts to be unwise and unscientific, since the abolition of vivisection would result in absolute paralysis of one branch of progressive and scientific medicine.

The following officers were elected for the ensuing year:

President, Dr. Francis S. Watson, of Boston.

Vice-President, Dr. J. William White, of Philadelphia.

Secretary, Dr. W. K. Otis, of New York.

The next meeting of the association will be held in Washington, D. C., at the time of the meeting of the Congress of American Physicians and Surgeons, in 1897.

Note.—A portion of the Transactions, which was omitted by mistake from this number will appear in the September issue.

THE NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY; STATED MEETING, HELD ON TUESDAY EVENING, MAY 12, 1896.

DR. W. K. OTIS, *Chairman.*

A Case of Peri-Urethral Abscess.—Presented by DR. W. K. SWINBURNE.

The patient was a young man who had a peri-urethral abscess of the frenum. It was treated in the following manner, which the speaker said he had found very satisfactory in these cases: The abscess was incised, scraped out with a sharp spoon, and then thoroughly cauterized with a solid stick of silver nitrate. A thick slough was formed, which fell off in two or three days, leaving a clean, granulating surface, which usually healed up rapidly. In reply to a question, Dr. Swinburne said he had never cut into the urethra in opening a peri-urethral abscess. There was usually quite a large abscess cavity.

DR. SAMUEL ALEXANDER said that for several years he had followed the method described by Dr. Swinburne, cutting down freely upon the abscess, and then cauterizing with carbolic acid. He had never cut into the urethra nor had he ever seen a case in which a fistula resulted. In some of these cases the abscess had a very long duct, which passed backward and entered the urethra at a considerable distance from the abscess cavity.

DR. J. R. HAYDEN asked Dr. Swinburne how soon he opened these abscesses. He had lately seen two cases in which fistulæ resulted.

DR. SWINBURNE replied that he advised immediate operation.

The CHAIRMAN, DR. OTIS, said he was in the habit of cutting down on these formations as soon as possible. He had never seen a fistula result.

Congenital Occlusion of the Urethra: Report of Operation for its Relief.—By DR. C. W. ALLEN.

On April 19, 1895, there was born in the Maternity Hospital on Blackwell's Island a male child. Upon the following day it was reported that no urine had passed. Examination showed that there was no meatus urinarius externus. An incision was made in the expectation that this would open into a channel, as is the case ordinarily. No opening was found, however, and the cut was extended somewhat deeper, and numerous attempts were made with a fine probe to force a passage through. The case was then referred to Dr. Allen, who performed an external perineal section. After entering the bladder and allowing the accumulated urine to escape, a probe was passed from the perineal wound into the proximal end of the urethra. The instrument became arrested in

the middle portion of the pendulous urethra, and from this point on the tissues were bored through, by forcing the instrument toward the artificial meatus already established. A section of a small-sized bougie was fastened in the anterior urethra. Antiseptic irrigations were made, and the perineal wound packed with iodoform gauze. The case was then transferred to the surgical service, and passed out of Dr. Allen's hands. A week after the operation the perineal wound was almost closed, and urine was being passed per urethram. The child died on May 16th, about a month after the operation. The only history obtainable was that on May 6th the child developed a high temperature, and was thought to have pneumonia. On May 10th jaundice appeared. At this time the urine was passed in very small quantities, and was of a dark-brown color. Before death the temperature became subnormal. At the autopsy it was found that the perineal wound was entirely healed. The left kidney weighed three ounces; the right, two ounces. Both kidneys were increased in size, and both ureters were distended with urine. The bladder walls were thickened; the urethra was pervious from the bladder to about one quarter of an inch behind the glans penis. The speaker said he did not know whether the passage of instruments was continued after the case had passed out of his hands.

Dr. J. P. Tuttle said he had never heard of a case like the one narrated by Dr. Allen. Several cases had been reported, however, where the urethra entered the intestine, and in one there was an entire absence of urethra.

Dr. Tuttle reported the following case to show the danger which may follow the use of the filiform bougie: Male, aged seventy-two years; family history negative. Has had several attacks of gonorrhœa, followed by stricture. The latter was treated by dilatation at irregular intervals. When he first came under Dr. Tuttle's observation no instruments had been passed for six months. There was continual dribbling of the urine, and the man was not able to pass more than a few drops at a time. On examination, a firm stricture was found at the anterior portion of the membranous urethra. On February 28, 1896, after considerable trouble, a filiform bougie was inserted, over which a tunneled sound was passed, and the urethra gradually dilated to No. 24, F. Subsequent to the operation the patient passed considerable urine voluntarily, but two days later he developed a thrombus of the left femoral vein, his temperature rose, and he had the appearance of one suffering from pyæmia. His urine showed the presence of waxy casts. The patient died on February 27th, with all the symptoms of sepsis. At the post-mortem the bladder walls were found to be very much hypertrophied; its cavity contained about five ounces of urine. Just anterior to the stricture in the urethra a false passage was found which entered the corpus spongiosum. The speaker said he was not positive whether this false passage was made by the filiform bougie or was due to the pressure of the urine after the operation.

An Anomalous Kidney and Ureter: Post-Mortem Specimen.—Exhibited by DR. R. H. M. DAWBARN.

The speaker said that while demonstrating nephrectomy on the cadaver he came across this unusual specimen. The kidney itself was flattened and elongated, and the ureter consisted of seven distinct tubules which terminated in a sac the size of an orange; from this sac a normal ureter extended to the bladder. The condition, he thought, was probably congenital. The opposite kidney was normal.

A Vesical Calculus of Unusual Size.—DR. W. K. OTIS exhibited a calculus removed from the bladder of a man thirty-six years old by the suprapubic method. The stone weighed two ounces and ten grains. A smaller stone was removed at the same time. Both the stones were hard, and were composed of uric acid with a thin covering of phosphates. The larger stone was firmly adherent to the vesical wall; for this reason litholapaxy was impracticable.

DR. HAYDEN, who assisted at the operation, said he had never before seen a stone so firmly attached. It took several minutes to dislodge it.

DR. ALEXANDER said that three or four years ago, at one of the meetings of the section, he presented a vesical calculus about the size of the one shown by Dr. Otis, which he had removed from a young man. In connection with the specimen he had made the statement that it was removed with great difficulty on account of its adherence to the base of the bladder, and several members who discussed the case questioned that fact. Dr. Otis's case proves that such a condition of affairs may exist.

The Diagnosis of Liquid or Semiliquid Formations in the Inguino-Scrotal Regions.*—By DR. THOMAS H. MANLEY.

DR. ALEXANDER said he did not entirely agree with the statement made by Dr. Manley in regard to the difficulty pertaining to the diagnosis of simple hydrocele. It is often difficult, however, to diagnosticate the various varieties of this affection. For instance, when we have to contend not only with a vaginal hydrocele, but also with an encysted hydrocele of the tunica vaginalis, it is extremely difficult to make a diagnosis without a free incision. The speaker said he had seen one case of this character where tapping of the vaginal hydrocele emptied both sacs; they quickly refilled, however, and an incision showed that there was a minute opening between the two.

Bacteruria.—DR. HERMANN GOLDENBERG read a paper on this subject. He stated that the subject of bacteruria, judging from the limited number of cases reported, is one quite novel in medical literature. It was first described by Roberts, in 1881, and much of what we now know on the subject was brought out by Ultzmann. Bacteruria is characterized, as the name implies, by bacteria in the urine, but not every case with bacteria in the urine can be classified under this term. Strictly

* See page 254.

speaking, the latter only applies to those cases where the freshly voided urine contained a large amount of bacteria. The urine was always cloudy, opaleseent, and had a peculiar, disagreeable odor. The reaction was acid or neutral; if it was alkaline, it was due to some other cause. The cloudiness did not disappear on boiling nor after the addition of a mineral acid. The urine did not become clear on filtering with the ordinary filtering paper, but it did so after passing it through a Pasteur filter or by shaking it with magnesia usta or carbonate of baryta. When properly filtered, the urine did not become opaleseent either on boiling or on the addition of an acid if the case was not complicated by bladder or kidney trouble. For microscopical examination a drop of aniline violet was to be added to a drop of urine on a slide, heated for a short time, allowed to eool, and afterward examined with oil immersion. Such an examination will reveal an abundance of micro-organisms of different shapes and sizes, sueh as the ordinary baeteria termo, the bacteria of intestinal fermentation, cocci, and bacilli. The baeterium coli commune seemed to be the most common cause of the disease.

Very little was to be said regarding the symptomatology of the disease. Subjeetive symptoms were generally absent. The peculiar odor was often the only thing that drew the attention of the patient to his ailment.

Etiology.—A question which is of the utmost importance in the ætiology of the disease is, How do the bacteria enter the urine? The answer was, Either through infection or through auto-infeetion. Ultzmann states that baeteruria is found in patients with malaria and in physicians who work in dissecting rooms, where the infeetion takes place through the respiratory organs. More frequent are the eases in whieh the bacteria enter the bladder per urethram through the introduetion of unelean instruments. Auto-infection took place from the intestines, either directly, by continuity, or indirectly, by absorption. As to the direct auto-infection, perforation of a prostatie abscess, either into the rectum and urethra or into the rectum alone, may be the cause of the bacteruria. There was, however, another way for the intestinal bacteria to enter the bladder—namely, through the lymphatics.

Treatment.—This depended entirely on the eause of the baeteruria. It was obvious that the therapeusis was different in cases due to an infection from without or to an infection from within. If the bacteria are introduced into the bladder through instrumentation, irrigation of the bladder and of the entire urethra with a solution of silver nitrate (1–2,000 to 1–1,000) was probably the most efficacious. Of internal remedies, salol or ol. gaultheriæ was to be recommended. Where there was a distended bladder and a disturbed contractility of this organ, the patient was to void his urine at short and regular intervals, as the distention of the bladder facilitated the decomposing action of the bacteria. If the baeteruria was due to a perforated abseess of the prostate gland,

and there was no direct communication between rectum and bladder, it was advisable to use massage to empty the prostate gland of the bacteria which were deposited in that organ. After this was done the patient should pass his urine, and then the empty bladder, with the entire urethra, was irrigated with antiseptic solutions. Much more difficult would be the treatment when we had to deal with bacteruria due to an auto-infection from the intestines. Theoretically, the indications were to prevent increased decomposition and fermentation *in loco nascendi* by means of intestinal antisepsis, or, if the fermentation is not abnormal, to prevent the absorption of the bacteria which under normal conditions inhabited the intestines. The number of internal remedies recommended for intestinal antisepsis was legion, and their value was inversely proportion to their number. According to Alber, intestinal antisepsis was illusory.

Dr. Goldenberg then reported in detail a case of bacteruria which he recently saw in consultation with Dr. Manges, of this city. The patient was a man thirty-three years old, in whom the cause of the trouble was finally located in the intestines, the case being one of auto-infection. Internal treatment proved of no avail. The patient was finally advised to take enemata of soap and water (two quarts), with a tablespoonful of borax added. Two of these were taken every day, one on rising, the other before retiring. The condition rapidly improved under this treatment. It was continued until two months ago. Since then the patient has been entirely well.

DR. F. TILDEN BROWN inquired whether a trace of albumin was present in the urine in Dr. Goldenberg's case while the bacteruria persisted. In one case coming under his observation, where the urine always contained the bacterium coli commune, sometimes in large numbers, a trace of albumin was also present.

DR. DAWBARN called attention to the fact that Ultzmann mentions as one method of auto-infection in these cases the diminished resistance of the tissues in diabetes mellitus, where we know the urine is often filled with microbes.

DR. FULLER said he did not think that cases like the one reported by Dr. Goldenberg are very rare. Some time ago he called attention to the fact that bacteria often exist in the seminal vesicles. In one case of bacteruria coming under his observation much improvement followed the internal administration of creosote. A small trace of albumin is always present in the urine in these cases.

DR. GOLDENBERG, in closing the discussion, said the urine in his case was repeatedly examined, and no albumin was ever detected.

Book Reviews.

The Year Book of Treatment. Philadelphia : Lea Brothers & Co., 1895.

This compilation is a valuable review in serviceable form of the work of the year previous to its publication. The several divisions of medicine are in the hands of men whose work is widely known, each in his particular field, and the literature of the world is sifted for the material finally selected as fit for use. In the departments of skin, venereal, and genito-urinary disease, the names of Malcolm Morris, J. Ernest Lane, and Reginald Harrison form a sufficient guarantee of that portion of the work at least. The subheadings under diseases of the genito-urinary system include hydatids, surgical kidney, uretero-lithotomy, Chismore's modification of Bigelow's litholapaxy, suprapubic cystoscopy and lithotomy, hernia of the bladder, castration for prostatic enlargement, treatment of purulent and offensive urine: under venereal diseases, injection of mercury in syphilis, other treatment of syphilis, chronic urethritis, alumnol and ichthyol in gonorrhœa (many of the references are from this Journal). Morris thinks we have made little advance in the therapeutics of skin disease, and that little chiefly in the line of criticism of old rather than in the introduction of new remedies. Lupus and thyroid treatment occupy his attention chiefly. The full reference is given whenever an author is quoted, and one of the chapters is given up to a selected list of books and translations—two useful features.

Physical and Natural Therapeutics. By Georges Hayem. Edited by Hobart A. Hare. Philadelphia : Lea Brothers & Co., 1895.

This book should prove useful to specialists in both the lines to which this Journal is devoted. Remedial measures, such as baths, electricity, heat and cold, change of climate, are, as the editor states, often of far greater value than the mere administration of drugs, and they are here set forth clearly, fully, and compactly, so that reference is easy. The work embodies not only Dr. Hayem's personal views, but those of other leading European therapeutists as well. In addition, Dr. Hare considers American health resorts and climates, subjects omitted in the original, but most useful in the English translation. The contents comprise Atmospheric Pressure as a Therapeutic Agent, Climate, Thermic Agents, Hydrotherapeutic Measures, Mineral Waters, Electricity. A striking feature is the clear and concise summing up at the end of each part. The subject of Electricity occupies one half the volume, and embodies the ideas of many writers—medical and lay—besides the author's own. Its value is enhanced by cuts representing various forms of apparatus and their methods of application.

Organic Materia Medica. By DR. JOHN M. MAISCH. Philadelphia: Lea Brothers & Co., 1895.

The work includes animal drugs, cellular vegetable drugs, and drugs without cellular form, classified according to their resemblance in physical and structural properties in such a way that by comparison the peculiarities of each are made clear. The object of the arrangement is to render detection of adulteration and determination of quality easy. The doses and treatment of poisoning by drugs are given, but it is stated that there is no intention of pointing out their therapeutic application. There is no mention of the toxic effects of the drugs. The consideration of each includes its origin, habitat, description, constituents, and properties. Illustrations of the portions of the plants used and their microscopic structure are profusely scattered through the volume. The work is a valuable one for reference along these lines.

Correspondence.

LIGATION OF THE VASA DEFERENTIA.

ST. LOUIS, MO., *April 25, 1896.*

Editor of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

DEAR SIR: A recent incident in my practice may be of some interest to your readers; it enlightened me considerably: On February 20, 1896, with stout silk I tied, as tightly as possible, both vasa deferentia, using a Lowry varicocele needle for encircling the ducts. Afterward, by vesicular massage and frequent microscopical examinations of the urine, it was demonstrated that at least one (possibly both?) of the ducts was patent enough to allow of the transmission of spermatozoa; they continued to appear in abundance until March 24th, when I resected both vasa after the method described by Mr. Harrison in the Medical Fortnightly, March 2, 1896. This latter necessarily cut off all further communication through the ducts. The spermatozoa that remained over in the seminal vesicles continued to appear, in diminishing abundance, at intervals for the next sixteen days, after which none were seen, though repeated examinations were made.

If simple ligation of the vasa fails to even obliterate their channels, as in the above case, can much be expected of it for eradicating the nervous communication between the testicles and prostate?

Respectfully, BRANSFORD LEWIS.

JOURNAL OF
CUTANEOUS AND GENITO-URINARY
DISEASES.

VOL. XIV. SEPTEMBER, 1896. No. 9.

Original Communications.

OPERATIVE INTERFERENCE IN AGGRAVATED INSTANCES OF SEMINAL VESICULITIS.*

BY EUGENE FULLER, M. D.,
New York,
Professor of Genito-Urinary and Venereal Surgery at the New York Post-Graduate Medical School, Visiting Genito-Urinary Surgeon to the City Hospital.

IN the book I wrote last year † I made a careful review of the literature relating to surgery in connection with the seminal vesicles. At that time I had not personally employed the knife as an aid in effecting a cure in any of my cases. Since then, however, I have obtained in this field operative results which have been alike gratifying both to my patients and to myself.

Aspiration of the seminal vesical, incision and drainage, and extirpation have been the surgical measures adopted in this connection.

In commenting on these procedures, I have condemned aspiration on the ground that any purulent condition of the seminal vesicle sufficiently uncomplicated to end in resolution after such an operation would recover in like manner without it. I have considered incision and drainage to be proper and essential in some inflammations, either acute or chronic, in which the suppurative process has extended beyond the limits of the seminal vesicle and invaded the perivesicular tissues. As regards extirpation I have said: "Most, if not all, the reported extirpations were undertaken for the removal of localized tubercular disease. The author, as has been stated, much prefers, as a rule, conservative methods in regard to cases of this nature, and would advocate

* Read at the June, 1896, meeting of the American Association of Genito-Urinary Surgeons.

† Disorders of the Male Sexual Organs, Lea Bros. & Co., Philadelphia, 1895.

extirpation only in instances where hygienic and tonic methods have failed or bid fair to fail. If malignant disease can be detected while still confined to this part, extirpation would, of course, be called for, in which case Rydygier's method would be advised as probably giving the best opportunity for careful investigation and thorough extirpation. Purulent perivesiculitis and disorganized conditions of the vesicle as might result from such inflammations or from calculi, from benign growths, and from traumatisms, might also be causes sufficient to demand extirpation of the vesicle."

Although at the present time I hold largely to the opinions I expressed a year ago, still my experience since then allows me to be more positive and authoritative. Among other things I know now just how difficult it is to remove *in toto* a seminal vesicle when it is the center of a mass of sclerous induration. Now also, instead of suggesting an operation on a seminal vesicle as a possible means of relief, I feel justified in urging such a procedure under certain conditions as a proper course to pursue in case a radical result is desired.

Routier, of Paris,* and Casper, of Berlin,† have lately written instructive articles on the treatment of prostatic abscess, so called, and of phlegmonous prostatitis. Although the prostatic source of the purulent collections in many of these cases can be doubted, as most abscesses in this region are really perivesicular, still the results obtained by these authors from their treatment is of interest. They both discuss the methods of giving vent to the pus. Routier considers that the rectal is generally to be preferred to the perineal route. To open the abscess *per rectum* he introduces a speculum and makes an incision in the spot which seems most available. He then washes out the cavity and leaves it lightly packed with iodoform gauze. He expects his cases after this procedure to leave the hospital cured in about ten days. Casper reports having opened such abscesses through the rectum eighteen times and through the perineum three times. He advises that these collections of pus should be opened as near the spot as possible at which they tend to point. Belfield has reported to me that on one occasion he has successfully drained a case of purulent seminal vesiculitis by means of an incision through the rectum. I have not as yet opened an abscess of this description by means of a rectal incision; still, in view of the results just quoted, I shall do so when a suitable opportunity presents itself. My operative experience has been in connection with extremely chronic non-tubercular cases

* La Semaine Médical, December 5, 1894.

† Berliner klinische Wochenschrift, May 27 and June 3, 1895.

of seminal vesiculitis, associated with which there has also existed a marked amount of sclerous perivesiculitis. The great majority of such cases yield gradually and satisfactorily to the stripping treatment I have advocated, and for these no treatment more radical seems necessary or advisable. To a small minority of them, however, the stripping treatment, for reasons to be considered, may not be applicable, and it is to these that I have applied radical surgical measures.

For its successful accomplishment in cases of this chronic class the stripping treatment requires that the patient should be subjected to its influence, intelligently administered, for six months to a year. Some can not meet such requirements. For such of those as have but few annoying subjective symptoms resulting from their disease, expectant treatment is advisable. To the remainder, however, who are crippled either mentally or bodily, or perhaps in both particulars, by their disorder any radical surgical operation which offers a chance for relief is warrantable and advisable. There are besides a small percentage of cases among those who faithfully submit to the stripping treatment with whom distressing subjective symptoms persist in spite of that treatment, and to such cases also the benefit of a surgical operation should be extended. In my present state of mind I should feel loath to advocate operative interference in cases of chronic tubercular seminal vesiculitis unless my object were largely to give vent to an associated collection of pus, thus anticipating the damage that might ensue from burrowing. For it would be impossible to eliminate the tubercular area in such a case, and then besides the extensive operative procedure which would be demanded to expose the disease would, in all probability, serve to extend the tubercular process and make it more general by debilitating the patient and by disturbing the surrounding tissues.

In extirpating the seminal vesicle the incisions which have been employed are the Zuckerhandl, the von Dittel, and the Kraske, or some modification of that latter incision such as was proposed by Rydygier. Occasionally a combination of two of these incisions has been found advisable. The descriptive accounts of the few operations which have been reported are meager. In practice on the cadaver it is an easy matter by means of the Zuckerhandl incision to reach and extirpate a normal seminal vesicle. In practice, however, where the conditions are pathological, the employment of that incision to reach the seminal vesicle has in my experience so many disadvantages that I have abandoned it. The pathway it affords is narrow and deep, and the arterial bleeding associated with its accomplishment is severe, since

large vessels are cut in a position where oftentimes they can not be readily secured; and when once the vesicle is reached in this manner pathological adhesions make it difficult or impossible for the operator by traction on the organ to bring it into reach, and most of the work of destruction has to be accomplished in a blind and unsatisfactory manner by the curette. My operative experience with this incision has been confined to two cases, in one of which I employed it in an attempt to reach a diseased seminal vesicle, but finally abandoned it for the Kraske incision; in the other I made use of it in closing a recto-urethral fistula. Dr. Charles B. Kelsey, of New York (New York Medical Journal, February 15, 1896), has used the Zuckerhandl method on one occasion in my presence in extirpating a seminal vesicle and makes the following comment regarding it:

"The operation has been long, bloody, and unusually difficult. In another case I should keep to the Kraske incision, which, though it seems unnecessarily large, renders the operation much more precise and is attended by much less bleeding and risk of tearing the rectum as we have done in this case."

The von Dittel incision also does not afford sufficient space. By its employment the prostate can be exposed, but in order to lay bare the seminal vesicle a higher cut, such as the Kraske, is required. In fact, the Kraske is the incision to be employed if the object of the operator be to extirpate the seminal vesicle. By means of this incision the seminal vesicle, the prostate, and the base of the bladder can be exposed freely and in a manner which permits the operator definitely and precisely to accomplish his purpose. The wound, to be sure, is extensive, but it must be borne in mind that the organ to be reached is deeply situated, and that the rectum has to be displaced before it can be exposed. The operation, however, is not bloody. A few good-sized vessels are cut, but their position is such that they can be readily and easily ligated. The operation is not particularly easy, and one has to know his anatomy well. Care has to be exercised not to wound the rectum, the base of the bladder, the ureter, or the peritoneum. The Kraske, being partially a lateral incision, of course exposes but one seminal vesicle. In order to expose both organs, incisions along either side of the lower portion of the sacrum would be required. I have not found it necessary, in doing the operation, to extend the incision up to the posterior superior spine of the ilium in order to acquire the requisite space, an incision the upper limit of which was opposite the middle portion of the sacral border having been sufficient. In unilateral cases, if the coccyx is not ankylosed to the sacrum, it is not usually neces-

sary to remove that bone, retractors laterally applied affording sufficient space. Rydygier's modification of Kraske's incision, which consists of a cut from the lateral sacral incision across the sacrum, just below the third sacral foramen, thus allowing a triangular flap of tissue and bone to be turned up in order to get a large amount of extra space, would, it seems to me, be necessary only in case one were dealing with a neoplasm or some condition requiring great exactness in the detail of extirpation.

My practice also on two occasions after completing the operation on the seminal vesicle has been to secure rest for the bladder by the introduction through a boutonnière perineal incision of a drainage tube. This arrangement has so far proved satisfactory. It may not, however, be necessary. It may be that a catheter tied in the urethra will be sufficient, or it may be that the bladder will be found to be capable of performing its function unaided. These are points, however, which I hope to settle to my own satisfaction from further experience.

The histories of the two cases I have to relate are as follows:

Case I.—Thirty-six years old; longshoreman. First seen by me in the spring of 1895. He was then unable to work, and for the last five years he had been able to do little at his calling, owing to a pain in his right suprapubic region, which always became intensified as the result of any active effort such as his work called for. Seemingly connected with this suprapubic pain there existed a desire to urinate, and this desire to urinate closely corresponded in its intensity with that of the pain. When his suprapubic pain became acute his urination became frequent and urgent; so much so, in fact, that at times he lost all control over that function. He was sexually weak. On attempting coitus his ejaculation was premature and painful. The act was followed also by an increase in his suprapubic pain. All these subjective symptoms had followed a gonorrhœa. That gonorrhœa had apparently been hard to cure. It had persisted as a gleet for a long time and on various occasions a relapsing discharge had appeared, especially after free indulgence in beer. His urine was as a rule clear and normal, with the exception of a stray shred. After one of his painful attacks, however, associated with tenesmus, it would contain some free pus. For his chronic symptoms he had sought relief at the hands of many surgeons. He had been searched for stone on numerous occasions, with negative results. He had been cut for stricture and dilated with sounds, all to no purpose. In fact, the treatment he had received had, as a rule, aggravated rather than relieved his condition. When he came under my observation I examined him most carefully and

diagnosed his trouble as a chronic seminal vesiculitis, confined almost wholly to the right sac. The rectal feel showed a hard tumefaction posterior to the prostate occupying the region of the right seminal vesicle. It was evident that the sac itself was imbedded in a mass of perivesicular sclerosis. Pressure on this tumefaction intensified the suprapubic pain and caused a thick pasty fluid of a brownish color to exude from the ejaculatory duct into the urethra. This fluid on microscopical examination was found to be from the seminal vesicle. The discoloration was due to blood pigment. A systematic stripping of the seminal vesicle was tried and the patient improved; but the sclerous mass was so extensive that I decided in October, 1895, to make a trial of extirpation of the seminal vesicle in order to hasten a cure. I first attempted to accomplish my purpose by employing the Zuckerhandl, the transverse perineal incision, but for the reasons already mentioned I abandoned it. In my attempts, however, through this narrow incision to bring down the sclerous mass into reach I tore the wall of the rectum. This same accident occurred at a later date to Kelsey in connection with his case, reference to which has already been made. To get more working space I then carried my incision (the patient lying on his belly with his buttocks elevated and his thighs bent downward) upward around the right border of the rectum and toward the coccyx. In other words, with my original transverse perineal incision I combined the von Dittel incision. Even then, however, I did not obtain sufficient space, and accordingly I extended the upper end of the last incision upward to the right of the coccyx and sacrum, its upper limit terminating opposite the middle portion of the right sacral border. This last cut, which was nothing more or less than the Kraske incision, afforded the required working space and showed my original transverse perineal as well as the lateral rectal incision to have been unnecessary. I now pushed the rectum to the left and exposed the sclerous perivesical mass, through which I made a longitudinal incision exposing the seminal vesicle along its entire length. The seminal vesicle, however, was so firmly imbedded in this mass that it was impossible to dissect it out with any precision. I accordingly snipped out as much of the organ as I could with curved scissors, finishing the work of removal with a sharp curette. The outlying sclerous mass I did not disturb for fear of injuring the ureter or peritoneum. I then successfully sutured the wound I had accidentally made in the rectum during the early part of the operation. My next step was to insert a long drainage tube at the upper, sacral, end of the incision, and pass it down through the space from which the seminal vesicle was extirpated and

out again beside the rectum. Around about the tube, to prevent oozing, a light packing of iodoform gauze was placed, and then the external cutaneous flaps were brought into proper apposition by silkworm-gut sutures. He was next put on his back in the lithotomy position and a boutonnière perineal incision made in order to make sure that no after trouble might occur from retention of urine. The patient made a rapid and highly satisfactory recovery and left the hospital at the end of three weeks and a half. At that time he complained that on moving about his urine would come away from him involuntarily, unassociated, however, with the old-time, right-sided, suprapubic pain. His extensive cicatrix was tender, causing him some pain when he sat down. Sinuses persisted, marking the position occupied by the drainage tube. He had no sensations of erection and felt that he was entirely impotent. All these symptoms proved to be associated with the after effects of the operation. They gradually became less and less and in February, 1896, over four months after the operation, the man reported well. He was then working hard alongshore. He had no pains. He could hold his urine naturally. His sexual power was strong and satisfactory and he reported that he was making liberal use of it. Digital rectal touch showed that the mass of sclerous perivesiculitis had disappeared.

Case II.—Forty-five years old; a cab driver. First seen by me in December, 1895. He was then depending entirely on a catheter, having been unable to pass a drop of urine naturally for over a year—ever since, in fact, he had undergone an external urethrotomy. His bladder was foul and his general condition bad, owing largely, as he expressed it, to attacks of chills and fever, which came as the result of exposure to cold or of physical exertion. He was married and the father of children, but within the last two years he had rarely attempted sexual intercourse, owing largely to disinclination and feelings of weakness, and when he had performed the act it was unsatisfactory and followed by pain and a lingering local distress. A large-sized sound slipped into his bladder easily, demonstrating that no stricture existed. The finger in the rectum showed what at first one might readily have diagnosed as extensive prostatic hypertrophy. The age of the patient, however, was against this, and the mass was very tender to pressure, a symptom not usual with simple hypertrophy. On careful investigation with the finger, however, I felt sure that the tumor was made up of an inflammatory exudation, which was focused about the right seminal vesicle. Palpation over the kidney region showed some tenderness, especially on the right side, and that, to-

gether with the history of chills and fever during the last year, made me suspicious that one or both of the renal pelves had been more or less involved by an ascending infection due to the chronic retention and the neglect of vesical antisepsis. The urine was alkaline or at best neutral. It contained much pus and bladder epithelia and some albumin, but as there was oftentimes a little blood present it was not safe to assume that the albumin was due to renal involvement. The patient stated that he had considered himself well with the exception of a moderate degree of sexual weakness till something over a year before, when he was suddenly seized with retention of urine. At that time he had been forced to remain on his box for a long time with a very full bladder before an opportunity had offered itself for him to urinate. The day was also very cold. A doctor was called and a catheter employed. He was then sent to a hospital and a perineal section performed and, as he stated, a stricture cut. He stayed in the hospital over two months. His bladder after the operation was drained for three weeks. After the perineal wound healed he was never able to pass any urine. The operation the patient thought afforded him no benefit and evidently did not reach the source of his trouble.

I determined to remove the post-prostatic perivesicular mass on the right side by means of a Kraske incision, in order to secure free and permanent vesical drainage. The patient was accordingly etherized and placed on his belly with his buttocks elevated, his thighs being allowed to hang down. The incision was made and the mass exposed. In this instance, owing to the rigidity of the coccyx, I dissected out and removed that bone. I made a longitudinal incision through the sclerous mass, as in the first case, and exposed the imbedded seminal vesicle, to which I then vigorously applied a sharp curette, thus removing the greater portion of the organ. I also made a boutonnière perineal incision, through which I introduced a catheter to insure bladder rest. In performing the operation the prostate was openly exposed, and it is interesting to note that it appeared perfectly normal in size and otherwise. The patient did well after the operation. The perineal vesical tube was removed at the end of a week and the perineal incision closed before the end of the fourth week. On the closure of the perineal wound the natural function of micturition returned just as in Case No. 1. Although he could hold his urine perfectly while lying down or resting, he found that his control over it was imperfect when moving about. This was also the complaint that Case No. I made for a month or so after leaving the hospital, at the expiration of which time the annoying symptom in his case entirely disappeared.

At the end of five weeks the patient was discharged from the hospital. His Kraske incision had healed with the exception of a small sinus, for the dressing of which he could be treated outside. During all his stay in the hospital a large amount of diuretic water had been prescribed in order to correct, if possible, the renal and vesical conditions which had resulted from the previous retention, and when he left his urine was clear and free from albumin. The renal tenderness had also disappeared. The patient reported very irregularly after being discharged from the hospital, and at the end of about a month I learned that he was laid up sick in bed. I accordingly visited him to investigate his condition. I found him feverish and very tender in both loins, but especially on the right side. After leaving the hospital he had stopped his diuretic water and had slept in a cold room with few comforts. About a week before my visit he had caught a cold, which had been followed by suppression of urine, and since that time it had been scant, high-colored, and loaded with pus. I examined a specimen which I took away with me, and found that it presented all the evidences of pyelitis. Digital rectal feel showed an entire absence of the original post-prostatic tumefaction. He emptied his bladder naturally, although the act of micturition had been very frequent since his attack of pyelitis. A small sinus still persisted near the middle of the Kraske incision. I offered to send him back to the hospital, and if necessary to do a nephrotomy to correct his pyelitis. He refused this proposition, and what the outcome of his case will be I do not know. Still, as far as the seminal vesicular operation is concerned, the case is certainly very successful, and had his position in life been different it is highly probable that nothing would have occurred to have prevented his kidneys entirely recovering from the damage they had sustained from the long-standing vesical retention.

From the foregoing operations the following conclusions can be drawn:

1. Chronic non-tubercular cases of seminal vesiculitis can be successfully and satisfactorily treated by extirpation of the sac.

2. Such an extreme measure, however, should be reserved for extreme cases associated with serious or severe subjective symptoms.

3. Before resorting to extirpation the patient should have the benefit of the stripping treatment, if his circumstances allow it, and extirpation should be advised only in case the stripping treatment proves unsatisfactory.

4. In performing the operation the Kraske incision is the method advisable.

5. The subjective symptoms associated with the seminal vesiculitis ought to disappear as a result of the operation.

6. With but one seminal vesicle, provided that organ is in itself healthy, the sexual function is strong and satisfactory.

7. A subacute epididymitis is to be expected after the operation in connection with the testicle corresponding to the seminal vesicle which has been removed. The testicle itself, however, does not subsequently atrophy.

CLINICAL AND PATHOLOGICAL REPORT OF A CASE OF CEREBRAL SYPHILIS.*

By GEORGE EMERSON BREWER, M. D.,
Attending Surgeon, City Hospital,

AND

PEARCE BAILEY, M. D.,
Assistant in Neurology, Vanderbilt Clinic.

THE object of this communication is to record the clinical history and the results of pathological examination of an unusually acute and rapidly fatal case of cerebral syphilis. Although the literature of the subject furnishes us with many accurate and carefully prepared clinical reports, and the results of a considerable number of painstaking pathological investigations, the number of cases which furnish both the clinical and pathological data is comparatively small; and as our increasing knowledge regarding the significance of each clinical symptom must be derived from a careful study of cases of this kind, and as our judgment in prognosis must be rendered more accurate by the recognition of the various pathological processes which may give rise to the same or similar clinical pictures, the following case is submitted, not because it presents any unusual feature or striking peculiarity, but with the hope that it may help to furnish data from which valuable deductions may some time be drawn:

The patient, F. M. A., aged twenty-five years, single, was first seen in the autumn of 1892. Family history negative. Aside from a moderate amount of neurasthenia, the patient had always had fair health. At the time of his first visit he complained of headache, sore throat, deafness, ringing in the ears, and general malaise. Upon examination,

* Read before the American Association of Genito-Urinary Surgeons, at Atlantic City, June 2, 1896.

an indurated ulcer was found on the penis with enlarged lymphatic glands in the inguinal, cervical, and epitrochlear regions. There was a well-marked macular syphilide on the chest and abdomen; mucous patches were found on the tongue, lips, and tonsils, and a well-marked otitis media on the left side.

The nature of his trouble was explained to the patient, and daily mercurial inunctions were prescribed.

He was seen at this time, in consultation, by Dr. J. Herbert Claiborne, of this city, who assumed charge of his aural complication.

Rapid improvement in all his symptoms followed, and after a few months of treatment the inunctions were suspended, and a tablet containing one quarter of a grain of protiodide of mercury with one grain of reduced iron was prescribed, in doses of from three to six daily. Shortly after this he returned to his home in the South, and for a period of eighteen or twenty months was under the care of another physician, who prescribed mixed treatment. The preparation used contained about one fiftieth of a grain of bichloride of mercury and fifteen grains of iodide of potassium to the dose. Toward the end of his second year he discontinued the mercury, and larger doses of the iodide were employed for a short time. During all this period he remained well, and free from noticeable manifestations of the disease.

He was next seen in March, 1896, about three years and a half after the original infection. At that time he complained of severe occipital headache, radiating down the back, which was paroxysmal in character, and accompanied by occasional attacks of vertigo. The pain was more severe at night, and was sometimes associated with nausea, vomiting, and extreme restlessness. Examination, at this time, by Dr. Bailey, revealed the presence of a slight enlargement of the left pupil, and a beginning double optic neuritis; marked increase in deep and superficial reflexes, no foot clonus, no paralysis of face or ocular muscles, no changes in sensation, no loss of sphincter control. He was given inunctions of mercurial ointment, one drachm daily, and potassium iodide in rapidly increasing doses. Marked improvement followed in all his symptoms during the first two or three weeks of the treatment. On April 20th, after five days of freedom from headache and all abnormal head symptoms, he was suddenly seized with loss of consciousness and an epileptiform convulsion, involving all the extremities. Ten hours later another slight convulsion occurred. He became restless, excited, incoherent in speech, and mildly maniacal. There was marked increase of all reflexes, slight left ptosis, but no other paralysis. The temperature, which up to the present time had

been normal, now rose gradually to 104°. The pulse remained below 100, was firm and regular. No embarrassment of respiration. April 24th, marked ataxia on standing, complete loss of all deep and nearly complete loss of superficial reflexes. No loss of sensation, no loss of muscular power, sphincters unimpaired. April 29th, temperature and pulse normal, right wrist-jerk returned, other deep reflexes absent. Left ptosis more marked, slight left facial paralysis, marked ataxia of upper and lower extremities. At this time he was receiving two inunctions daily of two drachms of mercurial ointment, and from a hundred and fifty to two hundred grains of iodide of potassium. From this time on the patient rapidly failed. The knee-jerks returned at one time and subsequently completely disappeared. The mental condition became more disturbed. He had hallucinations of sight and hearing, with illusions and occasional attacks of maniacal excitement. The iodide of potassium was pushed to a hundred grains three times a day, without improvement.

The urine at no time contained albumin, sugar, pus, or blood. On May 1st he sank into a comatose condition, with dilated pupils, irregular respiration, rapid and feeble pulse, and slight elevation of temperature. The sphincters relaxed, swallowing became more and more difficult, and he died on May 6th.

The autopsy, made a few hours after death, was necessarily limited to the head. The dura mater was slightly adherent to the skull at its apex, but elsewhere was entirely free. Both of its surfaces were smooth and of normal thickness and consistence. The pia mater appeared normal over the convolutions, but at the base of the brain it was opaque and thickened. The area of leptomeningitis extended from the cephalic border of the pons, where it surrounded the third nerves, to the medulla. It was limited laterally by the lateral borders of the pons. At the superior termination of the basilar artery, and inclosed by thickened meshes of the pia, was a round tumor, 7.5 millimetres in diameter. This tumor lay between the third nerves, slightly indented the pons, on the under surface of which it pressed, and the basilar artery communicated with it. There were no lesions visible to the naked eye in the walls of any of the blood-vessels, but there was a red thrombus in the basilar artery in the whole of its extent, and the upper portions of the vertebrals and part of the posterior communicating arteries were likewise occluded. There was nowhere any softening.

Microscopical examination of the structures at the base of the brain showed a leptomeningitis, endarteritis of some of the large arteries,

and an aneurismal dilatation of the basilar artery. (See cut.) The tumor before mentioned was formed by the dilatation of this artery, the walls of which were partially destroyed and infiltrated with polynuclear leucocytes and blood cells, some of which had escaped into the meshes of the surrounding pia mater. The intima of the basilar artery, especially at its caudal end, and that of some of the smaller arteries, was in places thickened to an extreme degree, and occasionally could be seen



Cerebral syphilis. The upper short line points to the eroded aneurism of the basilar artery; the lower line to the area of meningitis.

the beginnings of dissecting aneurisms, in places where the intima was torn away from the media, and where the blood was beginning to force its way between the two coats of the vessel. The middle and outer coats of these vessels were thickened in places, but only to a slight degree. The infiltration of the pia, which was most intense over the pons, was characterized by a perivascular round-cell infiltration of some of the pial vessels, and by the production of small round cells and polynuclear cells and a proliferation of the endothelial cells.

A consideration of the clinical symptoms and of the condition found

at the base of the brain after death indicated that the course of the disease was somewhat as follows:

The first manifestations of cerebral involvement, consisting of headache, optic neuritis, inequality of the pupils, and activity of the deep reflexes, were the results of an inflammation of the pia mater at the base of the brain. This process gradually yielded to the active anti-syphilitic treatment to which the patient was subjected; but although the meningitis underwent this improvement, there had developed changes in the blood-vessels, for the cure of which the iodide and mercury were powerless. Then resulted the thrombosis of the arteries at the base, which was announced clinically by the unconsciousness, convulsive movements, and loss of reflexes. The rupture of the basilar artery and the consequent effusion of blood must have been, from the morbid anatomical characters of the vessel, of slow development.

The case is of peculiar interest from several points of view.

When the patient had the apoplectiform seizures it was inferred by us that there had been a thrombosis of some of the cerebellar arteries. This opinion was based upon the frequency of thrombosis and the rarity of hæmorrhage in syphilitic lesions of the cerebral blood-vessels; and the seat of the process was located in the cerebellum from the ataxia and from the fact that many cases of disease of the cerebellum are accompanied by loss of the deep reflexes. But little is absolutely known of the functions of the cerebellum; but loss of knee-jerk is becoming to be regarded as an aid in the localization of cerebellar disease. The blood supply of the cerebellum is from the posterior inferior cerebellar arteries, which arise from the vertebrals, and the anterior inferior and superior cerebellar arteries, which are given off from the basilar. Although none of these cerebellar arteries were occluded, the thrombus extended from the vertebrals, below the point of origin of the inferior cerebellar, to beyond the point in the basilar where the anterior cerebellar leaves it. Thus, although the cerebellar arteries themselves were not occluded, the same effect was produced by the extensive clot in the larger arteries, which very much decreased the blood supply to the cerebellum.

The literature of acute cerebral syphilis is not extensive. Heubner's monograph (Die luetische Erkrankungen der Hirnarterien, Leipsic, 1874) still remains the most comprehensive treatise on the subject. From fifty cases of syphilitic arterial disease of the brain collected by him it appears that the basilar artery is selected as the seat of thrombosis in six per cent of the cases. Hæmorrhage is rare, and almost never occurs in great amount. Most of the acute fatal cases

are due to arterial disease. When the thrombosis is in the middle cerebral artery the result may be simply hemiplegia; but thrombosis of the vertebrals and the basilar is attended with a high mortality. The prognosis accordingly depends upon whether the process is limited to a productive inflammation of the membranes or connective tissue of the brain, or whether there exists in conjunction with or independently of this inflammation disease of the large arteries which may cause a diminution or loss of vascular supply to the cerebral structures. The prognosis varies with these conditions, not only on account of the increased danger of thrombosis *per se*, but as well from the fact that antisyphilitic treatment is much less effectual in arterial disease than it is when the morbid process is a gumma or a meningitis. Under all circumstances the prognosis should be guarded, for in cerebral syphilis thrombosis may occur at any time. The diagnosis of the anatomical nature of the syphilitic process is usually not difficult. Thrombosis, though it may be gradual, is usually followed by rapid development of cerebral symptoms. It may safely be said that with the exception of embolism, the large proportion of the cases of apoplexy occurring between the ages of twenty and forty years are due to syphilitic disease of the cerebral blood-vessels.

HYDROCELE—ITS RADICAL CURE.

By ORVILLE HORWITZ, B. S., M. D.,

Clinical Professor of Genito-Urinary Diseases in Jefferson Medical College; Professor of Genito-Urinary Surgery, Philadelphia Polyclinic; Surgeon to Philadelphia Hospital, etc.

AS the writer has had more than a usual number of cases of hydrocele under his immediate care within the last five years, it is thought that a few observations upon the disease and the methods pursued for its radical cure may not be uninteresting to the profession.

This dissertation is based upon the experience deduced from the treatment of one hundred and ten cases, of which fifty-nine were treated at the Jefferson Hospital, six at the Philadelphia Hospital, four at St. Joseph's Hospital, four at the Polyclinic, and thirty-six in private practice.

Of these, five began as acute hydrocele, ultimately becoming chronic and requiring radical operations; three were due to gonor-

rhœal orchitis; one case followed traumatism; one was intercurrent with an attack of acute articular rheumatism; and in one the hydrocele was double.

The varieties and the different forms of the disease are shown in the following table:

Ordinary hydrocele: fluid distending the tunica vaginalis	54
Congenital hydrocele	1
Infantile hydrocele	22
Inguinal hydrocele, associated with undescended testicle	1
Encysted hydrocele of the epididymis	4
Encysted hydrocele of the testes	1
Hydrocele of the cord	13
Hydrocele of the tunica vaginalis, with encysted hydrocele of the testes	1
Hydrocele complicated with inguinal hernia	12
Hydrocele occurring in an old hernial sac, the inguinal canal having become obliterated by the long use of a truss	1
Total	110

Table exhibiting the Various Ages of the Patients.

From one week to eighteen months	5
Between eighteen months and fifteen years	18
Between fifteen and twenty-one years	4
Between twenty-one and twenty-five years	9
Between twenty-five and thirty-five years	42
Between thirty-five and forty-five years	21
Between forty-five and sixty years	8
Between sixty and sixty-nine years	3

An examination of these tables shows that effusion of serum into the tunica vaginalis is by far the most common variety, fifty-four of the one hundred and ten cases being ordinary hydrocele; also that the condition is most frequently met with between the ages of twenty-five and thirty-five years.

Of the number treated, the effusion was present on the left side in sixty cases, on the right side in thirty-seven case, and the hydrocele was double in thirteen; of these, four began as an acute form of the affection, following gonorrhœal orchitis.

Hence it would appear that the left is more frequently affected than the right side, though this differs from the experience of other

observers, who seem to have found the right and left sides equally liable to the disorder.

Treatment is usually divided into palliative and radical. Treatment by the palliative method—that is, by draining off the fluid by means either of an aspirating needle or by a trocar—will not be considered in this paper.

The cases that are properly treated by the palliative method are those occurring in the very aged; persons who are broken in health or debilitated; who are suffering from some chronic disease of the viscera rendering a radical operation unjustifiable; those whose business engagements prevent them giving the necessary time required for a radical operation; and, finally, individuals who refuse other means of relief.

There are four methods of radical treatment recommended by writers on hydrocele:

1. Tapping the sac and injecting with an irritating fluid.
2. The Volkmann method.
3. Antiseptic incision.
4. Partial excision of the sac.

Tapping the sac is to be performed under the most rigid antiseptic precautions. After the fluid has been drawn off the cavity is to be injected with some irritating liquid, such as tincture of iodide or carbolic acid.

The patients usually suffer a great deal of pain after the operation. Very often the sac rapidly fills up, becomes as large as or larger than before the operation: and frequently the individual is confined to his bed for a period of from eight to ten days. There are many cases of suppuration following the treatment. There is danger, too, of the escape of the tincture of iodine or of the carbolic acid into the scrotal tissues, either at the time of the injection or on withdrawing the trocar; of slow absorption of the new fluid; suppuration of the tissue of the sac, and of renewed accumulation of fluid.

Dr. J. Murphy, in the New York Medical Record for June 20, 1891, reports the fatal termination of a case after the injection of carbolic acid, when death could only be attributed to the toxic effect of the remedy.

Of the fifty-four cases of ordinary hydrocele operated on by the writer, thirteen had been previously treated by other surgeons, by withdrawing the fluid and then injecting either tincture of iodine or carbolic acid. All had promptly relapsed.

When performing the open operation on these patients, no sign of

inflammatory changes could be detected; in a few cases the tunica vaginalis was possibly somewhat thicker than normal; in every instance the testicle was found to be freely movable.

Personal experience of this method of treatment has been unsatisfactory, and other means for the cure of hydrocele have long since been adopted by the writer.

Some years ago, when assistant to the late Prof. Samuel D. Gross and to Dr. Richard Levis (the surgeon who first suggested the use of carbolic acid in the treatment of hydrocele), many opportunities were presented for observing the effect of the injection of tincture of iodine and of carbolic acid; and the result was the conviction that it did not compare with the open method of treatment.

The open method of treatment of Volkmann, which is the next to be considered, is performed by making a free incision over the long axis of the tumor, opening the tunica vaginalis, stitching it to the skin, packing the wound with iodoform gauze, and then dressing the part antiseptically, the wound being allowed to heal by granulation.

The writer has performed this operation on two patients, the first case being one of ordinary hydrocele. The wound required from three to four weeks to close, when a large, unsightly cicatrix remained.

The second case was one in which the tunica vaginalis had undergone calcareous degeneration. As much as possible of the calcareous matter was removed by means of scissors and curette, and the wound packed with iodoform gauze. The patient made a slow but steady recovery.

Neither our personal experience nor what we have observed of cases in the hands of other operators allows us to advise the employment of this operation, except in those rare instances where calcareous changes have taken place in the sac. The length of time required for recovery is too great, and the operation is apt to result in a large everted scar.

The third method to be considered is that of *antiseptic incision with drainage.*

Of the fifty-two cases of hydrocele, thirty-one were treated by this mode.

The operation itself is a simple one. The part having been shaved and antisepticized, the patient is etherized, when the tumor is grasped by the operator and made tense with the left hand. An incision an inch and a half in length is rapidly made at the lower portion of the tumor, and the tunica vaginalis is opened. An assistant grasps the tunic with a pair of hæmostatic forceps affixed laterally on each side

of the cut, and pulls it forward into the wound. The fluid contents are allowed to escape, and the surgeon by means of a piece of bichloride gauze thoroughly dries the cavity; then the whole internal surface, together with the testicle, is thoroughly swabbed with pure carbolic acid by means of absorbent cotton attached to the end of an applicator; after which, the sac is loosely packed with iodoform gauze and the wound dressed antiseptically. The iodoform gauze is kept in place for twenty-four hours, when it is removed, and the cut surface of the tunica vaginalis drawn together. Within a few hours the serous surfaces adhere, and communication of the sac with the atmosphere is cut off.

The patient is generally enabled to leave his bed and the hospital on the fourth day, with but a small granulating wound of the scrotum remaining, which, under the application of the ordinary antiseptic dressings, heals kindly within a week. There is usually a slight painless enlargement of the testicle following the operation, which, however, subsides in a few days. In no case under the supervision of the writer did the temperature rise above 99°.

So far as is known, recurrence took place in but two instances; in each case the tunic was opened, and the sac, as far as possible, was removed.

The result of our observation, based on the experience derived from these cases, is the belief that this method of treatment is indicated when the affection is of recent origin, provided the sac has not been hitherto tapped, has not been injected with an irritating fluid, and when, on cutting down, the sac is found to be greatly thickened, and the tumor does not extend into the inguinal canal.

Partial Excision of the Sac.—Incision with partial removal of the sac is to be resorted to when the sac is found to be thickened, or where it protrudes far into the inguinal canal. Twenty-one of the fifty-two cases already referred to were thus treated.

A modification of this operation is suggested by the writer, which it is believed will greatly simplify the usual procedure:

It is performed by making a free incision over the long axis of the tumor, dividing the structures down to the sac, at the same time being careful not to open it. By means of an Allis's dry dissector, the scrotal tissues are to be quickly separated from the tunic, which is to be left slightly adherent posteriorly; this being the portion of the sac which covers the cord, and is not to be disturbed. The sac is then made tense, fixed by means of a tenaculum, opened by a touch of the knife, and the fluid allowed to escape. The sac, having been thoroughly dissected

from the scrotal tissue, is to be removed in a single piece by means of the curved scissors. The bleeding vessels are ligated and the wound dried. Should there be much hæmorrhage from the edges of the cut sac, it must be controlled by a continuous suture passing completely over the margin. The portion of the tunica vaginalis lying over the cord is to be swabbed with carbolic acid, the wound irrigated with 1-to-1,000 bichloride solution, a small drainage tube inserted, and the parts closed by silkworm-gut suture. An antiseptic dressing is then applied. The drainage tube is to be removed after twenty-four hours; the sutures after the seventh day.

In but two cases has the writer seen any trouble arise from this operation. In one the patient returned to the hospital six months after having been discharged, suffering with a sinus in the scrotum, which had presented itself three months after he had quitted the institution. On examination a silk ligature was discovered, which being removed, the opening promptly healed.

The second case occurred on a man whose bed in the hospital was near the toilet room; unseen by the nurse, he arose and went to the closet, where he removed the dressings; being unable to properly replace them, the parts were exposed for some hours before his condition was discovered. The wound became infected; suppuration ensued; it became necessary to remove the sutures, and to pack the parts with iodoform gauze. The patient recovered in about four weeks.

Recurrences after partial excision of the sac have been reported, but no relapses have taken place in cases treated by this method.

The advantages of dissecting the sac free from the scrotal tissues are:

1. Saving of time. 2. The removal, without difficulty, of all that is necessary to be cut away without tearing the tunic into strips or patches. 3. There is less hæmorrhage; the sac which is removed being distended with fluid, the small vessels from the surrounding tissues are torn and do not bleed. But if the membrane be opened and the fluid allowed to escape, the tissue has necessarily to be dissected away with either scissors or knife, resulting in the cutting of numerous small vessels, requiring the application of the catgut ligature.

Congenital hydrocele can generally be cured by means of a properly adjusted hard-rubber truss, the fluid being removed from time to time by acupuncture. Should this fail, it is recommended to draw off the serum with a small trocar and inject either tincture of iodine or carbolic acid into the cavity, care being taken to have a well-fitted truss applied during the operation; an antiseptic incision is, however,

much to be preferred, not only because it is safer, but because it admits of a radical operation for hernia, should such a complication be present.

An open operation in the case of infants is not recommended, as it is quite impossible to keep the wound in an antiseptic condition when infection might ensue. Should the child have reached the age of nine years, the operation may be performed with safety.

In a case upon which the writer operated, the parts were sterilized and an incision made over the lower part of the inguinal canal and the upper portion of the scrotum, precisely as though operating for hernia.

The funiculo-vaginal process was separated from the cord, the serous membrane divided immediately above the testicle, and parted from the adjacent structure as far up as the internal ring. It was then twisted, tied with catgut ligature, and the portion below the ligature cut away. A very small drainage tube was inserted for twenty-four hours. The patient promptly recovered, and thus far there has been no recurrence of the malady. It may be well to state that the internal ring can be readily reached without making a very large incision, if the upper part of the wound be well retracted.

Infantile Hydrocele.—Of the twenty-two cases of this variety that came under the writer's observation, seventeen were cured by means of numerous punctures made with a Glovins's needle. The needle should be sterilized and the skin antisepticized in the usual manner. The operator grasps the tumor with the left hand, makes it tense; then, taking the needle in the right hand, between the thumb and forefinger, he rapidly makes six or eight punctures into the sac, rotating the needle once or twice with every perforation, at the same time being very careful not to wound the testicle, and bearing in mind to hold the scrotum tensely until the serum contained in the sac is evacuated. This procedure has usually to be repeated at intervals of from eight to ten days. Five or six operations are necessary to effect a cure. In five cases in which this mode of treatment failed, an antiseptic incision was resorted to; the cavity was dried, swabbed out with carbolic acid, and packed with iodoform gauze in the manner previously described. The patients all made prompt recoveries.

Hydrocele associated with undescended testicle is by no means common. In the single case upon which the writer operated, the tumor was situated at the abdominal ring, projecting partly into the canal, and was about the size of a turkey's egg. The undescended testicle was on the left side; the scrotum was fully developed. A free in-

cision was made over the tumor and scrotum. The tunica vaginalis was then dissected loose without opening the sac. The tunic was next incised, and the fluid allowed to escape; the testicle was brought down and stitched in place at the bottom of the scrotum. A drainage tube was inserted and the wound closed. The patient made a favorable recovery.

The cases of *encysted hydrocele of the epididymis* or cord were treated by making a free incision, opening the tunica vaginalis, and by means of a dry dissector removing the sac in its entirety, and then closing the wound.

In one instance, when operating upon a case of hydrocele of the cord, while attempting to excise the sac, it was suddenly ruptured and it became necessary to freely open and remove the membrane.

Hydrocele of the tunica vaginalis with encysted hydrocele of the testes is a very rare condition. But one case has been under the writer's charge. The tumor had been growing for seventeen years; its length was twenty-six inches, and it was eighteen inches in circumference at the base; it contained four quarts of fluid. In operating on this case a free incision was made over the long axis of the tumor, and the tunica vaginalis opened, when a large quantity of fluid escaped, exposing the testicle, which was about the size of the head of a fœtus at term. The cord was isolated, tied, cut, and the testicle removed. On opening the testicle after castration it was found to be nothing more than a large sac formed by the tunica albuginea containing fluid. Every vestige of the glandular structure had long since disappeared; the redundant scrotum was retrenched, a drainage tube inserted, and the wound closed. The patient quitted the hospital on the thirteenth day.

Of the twelve cases of *hydrocele complicated with inguinal hernia* no difficulty was experienced in operating; care being taken to apply an accurately fitting truss with antiseptic gauze, prior to commencing proceedings, in order to retain the rupture in place.

Seven cases were treated by antiseptic incisions together with carbolic acid. In the remaining five the sac was partially removed. In two of the cases, the consent of the patients having been obtained, the operation by the Halstead method for the radical cure of the rupture was performed. The patients recovered without any untoward symptoms.

In a case of effusion of serum in an old hernial sac where the inguinal canal had become obliterated, an incision was made down to the sac, which was dissected loose from the adjacent structures with-

out penetrating it. It was then removed at the external abdominal ring, care being taken not to open the tunica vaginalis.

In the thirteen cases of double hydrocele, the open operation was performed on both sides simultaneously. They all made rapid recoveries.

The details of the treatment of the cases of hydrocele by the methods advocated in this paper would seem to warrant the belief that where proper antiseptic precautions are observed, the open method of operating is not only the most satisfactory, but the safest method of procedure; by it the operator is enabled to know exactly with what condition he is dealing, and at the same time the patient is offered the best chance for a permanent recovery, with little or no attendant pain.

Society Transactions.

THE NEW YORK DERMATOLOGICAL SOCIETY.

Two Hundred and Fifty-second Regular Meeting, held on Tuesday Evening, April 28, 1896.

Dr. C. W. Cutler, *President, in the Chair.*

A Case of Lenticular Carcinoma of the Skin.—Presented by Dr. Lustgarten.

The patient was a man, aged about fifty years, an inmate of Mount Sinai Hospital. His previous history was unimportant, with the exception that he had always used tobacco and alcohol to excess. He had never had rheumatism, nor œdema of the feet, nor any venereal disease. His present condition was of two months' duration. He complained of loss of appetite and diarrhœa, alternating with constipation. Three weeks ago numerous subcutaneous nodules appeared over the entire body. There were no subjective symptoms. The tumors were flat and indurated and seemed to take their origin in the deeper layers of the cutis. Examination *per rectum* showed quite a large tumor situated immediately above the sphincter. Dr. Lustgarten said he regarded the case as one of lenticular carcinoma of the skin, secondary to some visceral growth.

Dr. Bulkley said if this was a case of lenticular carcinoma of the skin, it was different from any that he had ever seen. In carcinoma the lesions were usually thickly set, on a firm, dense base, and not isolated and movable as in the present instance.

DR. PIFFARD said the case impressed him as being one of multiple fibromata.

DR. FORDYCE thought the case was one of multiple carcinoma. A microscopical examination of one of the lesions as well as the general appearance of the man tended to confirm this diagnosis.

DR. C. W. ALLEN said he thought the lesions were malignant in character. Their development had been much more rapid than would have been the case with fibromata.

DR. H. G. KLOTZ agreed with Dr. Lustgarten that the case was one of carcinoma. He years ago observed a case in which similar nodules spread from a cancer of the breast; they gradually covered the entire thorax, were as firm as those in the present case, but after a time broke down and formed ulcers.

DR. SHERWELL also regarded the case as one of carcinoma. In a similar case coming under his observation, where he was called in to differentiate the disease from leprosy, the primary growth occurred in the mediastinal glands. In that case death seemed to occur as much from compression of the vessels in the upper thorax as from exhaustion incident to the disease.

DR. LUSTGARTEN, in closing the discussion, said that the microscopic picture of the lesions in this case excluded the diagnosis of fibromata; besides, an acute eruption of fibromata under conditions such as these was unknown. The cachectic appearance of the patient made the diagnosis of malignant disease highly probable.

A Case for Diagnosis.—Presented by DR. BRONSON.

The patient was a woman of about thirty years of age, unmarried, laundress. She had been under Dr. B.'s observation since January of this year. She stated that the skin affection from which she was still suffering had begun in November, 1895, together with some trouble in the throat, attended with hoarseness, at times amounting to aphonia, and swelling of the glands on the left side of the neck. The skin eruption first showed itself on the forehead in the form of papules which spread in a concentric form. Similar papules in clusters appeared later on other parts of the face and on the extremities. They had never affected the trunk. There was no itching that was noticeable. When first seen in January there was a large patch of eruption on the forehead that was somewhat crusted in places, but for the most part consisted of rather dusky red papules varying in size from lenticular to miliary. On other parts of the face, the cheeks, the ears, and the chin, there were similar papules in clusters, but more discrete than on the forehead. Near the elbows and on the forearms there were other clusters, and here in one or two places there was pustulation. At one place a slight scar had formed, but elsewhere the suppuration was only superficial. There were one or two similar groups about the ankles, but none higher up. The skin, however, appeared dry and rather ill-nourished. In appearance these groups of papules, chiefly because of their

dusky color and arrangement, suggested a syphiloderma, notwithstanding that there seemed more of an irritation or inflammatory character about the eruption than commonly belongs to syphilis, and the papules did not show the well-defined margins of syphilitic papules. There was a large mass of greatly hypertrophied glands in the neck, and from some interior affection of the throat the patient was unable to speak above a whisper. The mucous membranes of the mouth and genitals were entirely free from disease. Though the case seemed somewhat obscure, the diagnosis was made, partly by exclusion, of syphilis, and the patient was treated locally and generally by mercury, even to the extent of mild mercurialism. But after a few weeks it became evident that the more this treatment was pursued the worse the eruption became. It spread more rapidly and became more inflammatory, and new groups of papules appeared. Under simple expectant treatment, afterward with merely soothing measures locally, the progress of the disease seemed to be arrested, and latterly, with applications of resorcin and ichthyol, there had been very decided improvement. The hoarseness still continues. Dr. Robert C. Myles had reported that over the crico-arytænoid cartilage there was a lesion which he characterized as an "herpetic ulcer."

[Since presenting this case the enlarged glands in the neck have been removed by surgical operation, and at this writing, June 1st, the eruption has entirely disappeared.—E. B. B.]

Dr. Fox said he did not care to venture a diagnosis. The eruption certainly resembled a tubercular syphilide, although the light color and scaly appearance of the lesions on the arms did not tend to confirm that diagnosis.

Dr. A. R. Robinson said that when he first saw the case, which was some time ago, when the eruption was in an acute stage, he thought it was either a syphilide or possibly an erythematous lupus. Now, however, he was inclined to agree with the diagnosis which Dr. Bronson would suggest after the discussion was closed.

Dr. Jackson said that while he had no positive diagnosis to offer, he thought the case looked more like an erythematous lupus than anything else. The lesions on the ears have the atrophic appearance which we see in such cases.

Dr. Sherwell regarded the case as one of lupus erythematosus of the discoid form, and not as distinct as it might be.

Dr. Allen said he had no diagnosis to offer. He was fairly certain, however, that it was not syphilis.

Dr. Fordyce said the lesions did not correspond with any type with which he was familiar. He did not think that the case was one of lupus erythematosus.

Dr. Cutler said that, without any history, he would regard the eruption as syphilitic. If not that, he would be inclined to consider it a form of lupus erythematosus.

DR. BRONSON, who presented the case, said he had received a good deal of comfort from the discussion, because of the uncertainty of the members as to the diagnosis. When he first saw the patient, he immediately made a diagnosis of syphilis, although no history of that disease was obtainable, and the woman, who has been laundress in a private family for many years, bore an excellent reputation. Energetic antisyphilitic treatment, however, consisting first of the administration of protiodide pills, followed by inunctions, served only to aggravate the disease, the lesions becoming more inflammatory. By exclusion, Dr. Bronson said, he had now made a diagnosis of dermatitis herpetiformis, and though in many respects it did not correspond to Duhring's cases, it had the more essential characteristics of the disease. He believed it to be an herpetiform inflammatory disease and due to some neuropathic cause. Neither the presence of suppuration nor the absence of itching was sufficient to exclude the diagnosis. The speaker said he could not regard the case as one of lupus erythematosus; he did not see how that disease could run such a course; it certainly is not of the discoid form, as suggested by Dr. Sherwell; if anything, it belongs to the disseminate form of Kaposi.

DR. KLOTZ asked whether it was not very uncommon in dermatitis herpetiformis that the lesions extend to the face. The condition of the ears in this case seemed to be entirely different from dermatitis herpetiformis.

DR. BRONSON said he did not consider this a typical case of dermatitis herpetiformis; on the contrary, it was anomalous in many of its features. The lesions are improving under applications of resorcin and ichthyol and general tonic treatment. He would not expect such improvement if the case was one of lupus.

DR. FOX said he had seen the face involved in dermatitis herpetiformis.

A Case of Angiomata of the Face.—Presented by DR. FOX.

The patient was a girl with a number of punctate, bright red lesions on the cheeks and two whitish lesions on the forehead. This case, the speaker said, was similar to one presented by him several months ago, with lesions very much like these on the face and a whitish raised patch on the back. In this case the lesions made their appearance about seven years ago.

DR. FORDYCE said he regarded the lesions as angiomata. In some of them, in addition to the dilated vessels, there appeared to be a formation of fibrous tissue.

DR. JACKSON said that when he first saw the case it struck him as being one of angiokeratoma, or kerato-angioma, although most of the cases of angiokeratoma reported had been on the backs of the hands. He agreed with Dr. Fordyce that some of the lesions contained a certain amount of fibrous tissue.

DR. LUSTGARTEN considered the case an angioma.

DR. FOX, in closing the discussion, said the tumors in this case seemed

to be quite solid in formation, the vascular condition being secondary. An interesting point regarding these cases is their chronicity: in both that have come under his observation the lesions were on the cheeks and forehead; they persisted for many years and gradually became worse in spite of active treatment. The only condition similar to this described in the text-books is that given by Crocker under the name of lymphangiectodes.

A Case of Pityriasis Rosea.—Presented by Dr. Fordyce.

The patient was a young girl with an eruption of about three weeks' duration. It first appeared as a single lesion on the abdomen and then spread over the entire body. The lesions produced considerable itching; they were slightly scaly and clear up in the center, leaving a brownish discoloration.

Dr. Bronson said that in the treatment of pityriasis rosea he has obtained the best results from germicidal applications. He asked the opinion of the members as to the parasitic nature of this disease.

Dr. Fox said that, in his experience, some cases get well without any treatment, while others persisted in spite of the application of germicides. Stimulating applications, whether germicidal or not, usually produce a beneficial result. The speaker said he did not regard these cases as parasitic in origin.

Dr. Jackson said he thought Dr. Fordyce's case was particularly interesting, as it showed the primary patch upon the abdomen, which is considered by some as very important. He did not regard the disease as due to the trichophyton fungus, although it had been described by Hebra under the title of herpes tonsurans maculosus et circinatus.

Dr. Bulkley said he had commonly seen a pityriasis rosea begin on the neck and shoulders and then spread over the body, and that it had always impressed him as being of microbic origin. He quite agreed with Dr. Bronson that the best results were obtained from the application of antiparasitic remedies, particularly a solution of bichloride.

Dr. Lustgarten said that Hebra, at a very early period of our ætiological knowledge, called this disease herpes tonsurans because he found mycelia in some of these cases. The speaker said that he had had a similar experience. While it is probably not identical with true trichophytosis, everything tends to show that it is a parasitic disease. It is probable that all the eruptions which we call pityriasis rosea are not identical in their ætiology.

Dr. Sherwell said he had never been able to associate pityriasis rosea with a parasitic origin. He had seen two or three cases in which the eruption made its appearance during the puerperal period; in one case it had occurred at every one of such periods.

Dr. Klotz expressed the opinion that this case corresponds closely to the description of the disease given by the French writers. In such cases he had never seen a beneficial result from any form of treatment.

Those cases, however, which presented more striking symptoms, more intense redness, and particularly more distinct scaling, seemed to yield to antiparasitic treatment.

DR. ALLEN said that clinically we must recognize two varieties of this disease, namely, pityriasis rosea and herpes tonsurans circinatus. While these may closely resemble one another, the latter usually spreads much more rapidly than the former. In the first form the original patch, according to Brocq, may occur anywhere on the trunk. In one case referred to him by Dr. Brocq himself, the original spot was upon the upper chest, whence it spread very slowly and finally covered about half of one side of the chest. As a rule, the eruption disappeared in the course of a few weeks. He had one patient under his care who had had at least seven attacks; this patient was an habitual drinker of spirits, and a curious fact in connection with the case was that three or four of his attacks of pityriasis rosea have come on shortly after New Year, when he had resolved to "swear off" drinking, which latter process seemed to disturb his digestive organs in a marked degree.

As regards the parasitic nature of the disease, the speaker said that in one case which he had examined with Dr. Leviseur the scales showed the presence of a form of mycelia similar to those of trichophyton, but smaller. He has under his observation a Turkish bath attendant, who has developed this form of eruption a number of times, though almost constantly undergoing a steaming and washing of the surface.

DR. PIFFARD said he was inclined to regard pityriasis rosea as parasitic in origin. Mild treatment was usually very satisfactory. In most of the cases that had come under his observation the eruption disappeared under applications of chrysarobin. It was probably due to some form of skin fungi, which as yet have not been properly classified by botanists. Of fungi in general (including micro-fungi), between forty and fifty thousand species have been described.

DR. FORDYCE said there was a disseminated form of ringworm which closely resembled pityriasis rosea. In the former, however, the lesions were smaller, seldom reaching the size of those seen in pityriasis rosea. The speaker said he regarded the disease as parasitic in character. Some years ago he saw two patients, a man and his wife, with the typical lesions of pityriasis rosea; in both, the lesions appeared about the same time.

DR. PIFFARD exhibited a slide under the microscope showing the trichophyton microsporon eetothrix stained by Gram's method.

A Case of Lichen Planus.—Presented by DR. A. R. ROBINSON.

The patient was a colored woman, a native of Virginia. The eruption made its appearance two months ago. There was a marked contrast between the lesions on the body and those on the lower extremities, the former being of pinhead size, while the latter consist of large, pigmented spots. Dr. Robinson said he had never before seen a case of lichen planus in a colored person.

Dr. Bronson said that he had never seen this eruption in a negro.

Dr. Fox said he had seen three cases of lichen planus in the negro.

Dr. Lustgarten considered Dr. Robinson's case a very interesting one, and referred to the melanotic appearance of the lesions on the lower extremities.

Dr. Robinson, in closing the discussion, said that a curious feature of this case was the combination of what might be called the verrucous



Dr. Abrahams's case of myxœdema after beginning the thyroid treatment.

form of lichen planus on the limbs with the pinhead-sized lesions on the trunk. As a rule, the lesions were pea-sized, or larger.

A Case of Myxœdema.—Presented by Dr. Lustgarten for Dr. R. Abrahams (see cut), who gave the following history of the case: Female, aged fifty years; the mother of nine children; previous history negative. Two years ago she passed her climacteric. One year ago she weighed one

hundred and twenty-five pounds; now she weighs two hundred and fifteen. She noticed an increase in her size six months ago. The symptoms appeared in the following order: (1) Constant chilliness, (2) pricking sensations in the tips of her fingers, (3) total check of sweating, (4) tongue increased in size and speech became laborious, (5) complete loss of memory, (6) hands and fingers became unwieldy, so that she could not close or bend them, (7) gait very waddling. All these symptoms were very prominent on February 29th, when Dr. Abrahams took charge of her. In addition he found her drowsy and extremely weak. Her hair was falling out. Excepting the skin over the hands, all the rest of her cutaneous surface showed no scaling or roughness. She was somewhat anæmic; the usual circumscribed flush on the cheeks was absent. All the organs in the body, after very careful examination, were found normal. The temperature was somewhat below the normal standard.

Since March she has been taking thyroid extract (Parke, Davis & Co.). She began with one-grain doses three times daily. She is now taking five grains three times daily. It was unfortunate that she was irregular in taking the drug. Yet there was an improvement in her condition; even the patient appreciates the change. She sweats profusely; the diminution in the size of her tongue is particularly marked; her speech is easy; the skin over the hands is getting loose; her memory is much better, and her corpulency is abating. The hair has stopped falling out.

DR. BRONSON inquired whether any of the members had tried the thyroid extract in scleroderma.

DR. JACKSON said that in one case of scleroderma in which he had employed the thyroid it did not do a particle of good, although the patient took the drug up to the point of intoxication and continued it for some five or six weeks.

DR. PIFFARD said that while the use of thyroid extract was justifiable in some cases, he considered it a dangerous drug to experiment with.

DR. KLOTZ referred to a case of scleroderma mentioned by Dr. B. Sachs at a recent meeting of the Academy of Medicine as very much benefited by thyroid. It is probable that in all cases where this treatment proves beneficial it must be continued indefinitely; if the treatment is stopped, the disease will recur. For this reason it is preferable not to increase the dose too much.

DR. ALLEN said that the reports of cases of myxœdema treated by thyroid were so uniformly favorable that it would seem scarcely right not to give these patients the benefit of this treatment. The dose of the thyroid, he thought, could be gradually increased with advantage. He had employed it in larger dose in obesity.

DR. SHERWELL said that at a recent meeting of the Academy of Medicine, Dr. Dercum, of Philadelphia, read a paper on the subject of scleroderma, and in the discussion that followed some of the speakers expressed the opinion that scleroderma, in its ætiology and pathology, bore relation

to myxœdema, morphœa, facial hemi-atrophy, Raynaud's disease, etc. At that meeting Dr. Sachs reported that he had employed thyroid extract in a case of scleroderma with marked benefit.

Dr. Lustgarten said he saw Dr. Sachs's patient three or four years ago, and it impressed him as being a somewhat atypical case of myxœdema. There was a diffuse infiltration of the skin; the tongue was enlarged and the patient had a peculiar defect of speech. Cases of scleroderma have been described which were favorably influenced by thyroid, but we should not lose sight of the fact that diffuse scleroderma shows a marked resemblance, in some respects, to myxœdema.

He said he had employed almost exclusively the thyroid preparation made by Parke, Davis & Co., which he had found very active. He had never been able to go beyond five grains, three times daily, and many patients could not take even that dose. Women were often intolerant to even two grains, three times daily. He had employed thyroid with good results to correct menstrual irregularity. In women with myxœdema menstruation will cease and the sexual desire be abolished early in the course of the disease, and he was inclined to think that there is a relationship between a defective thyroid function and a defective genital function. In young girls with menstrual irregularity he usually gave very small doses of the thyroid, beginning about a week before the time, and this frequently regulated the flow and prevented the periodical recurrence of acne on the face.

Dr. Piffard said that he was the first to point out the essential difference between the two types of scleroderma, which he illustrated with two cases. One improved very decidedly under galvanization, while the other got well of itself. To one he applied the name scleroderma and to the other scleriasis.

Dr. George T. Jackson showed colored pictures of a case of nævus verrucosus occurring in the person of a young mulatto woman whose color is nearly white. She is a patient of Dr. E. B. Kilham, of the New York Infirmary. As long as she can remember she has had brown spots like freckles on the right arm and a warty growth in the right axilla. When she was fourteen years old the nævus began to grow rapidly and to spread over the chest and back as brown spots, and in the axilla as papillomatous excrescences. The growth ceased from spreading when she reached the age of twenty-one years.

The nævus was remarkable for its limitation to the upper right quadrant of the trunk and the right arm, and for the distribution of the lesions in well-marked lines. Aside from the parts shown in the drawing there is a single warty nævus at the umbilicus, and the pigmentary lesions extend much farther down the arm than shown here. The lesions were of all kinds—some being simply like freckles, some being raised and warty, some being papillomatous, forming tumors of large size. The color of the different lesions also differs very much, varying from a light brown to an

almost inky black. The most remarkable and striking feature of the case is the series of circles, one within the other, that the lesions assume on the breast, and that in the living subject is even more marked than the artist has shown.

DR. FOX said the case reported by Dr. Jackson is an interesting type of an affection to which unfortunately many names have been applied. One of these, ichthyosis hystrix, is evidently a misnomer, while the term nævus verrucosus is an excellent one. In many of these cases the lesions do not follow the distribution of the cutaneous nerves.

DR. A. R. ROBINSON thought the term ichthyosis hystrix was quite improper in a case like the one reported by Dr. Jackson. In that case the papillæ are enormously enlarged, whereas in ichthyosis no change whatever occurs in them.

Report of Cases presented at Previous Meetings.—DR. LUSTGARTEN reported that in the case presented by him several months ago, that of a young girl with warty lesions in the mouth, the microscope showed that they are papillomatous in structure.

Dr. Lustgarten also reported that his patient with condyloma fungoides, who was presented about two years ago, had died. He developed enormous infiltrations in the submaxillary regions, probably originating from the glands.

AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

TENTH ANNUAL MEETING, HELD AT ATLANTIC CITY, N. J., JUNE 2 AND 3, 1896.

SECOND DAY, WEDNESDAY, JUNE 3D.

DR. CLAUDIUS H. MASTIN, *President, in the Chair.*

(Concluded from page 321.)

Post-conceptional Syphilis.—DR. ABNER POST, of Boston, read a paper on this subject. He stated that regarding the possibility of intra-uterine infection of syphilis two opinions prevailed, one party affirming and another denying its existence; while a third party may be said to consist of those who admit its possibility up to a certain period of pregnancy and deny its possibility after a date which is set at various periods by different writers. Those who deny the possibility of such transmission rest their belief upon the well-known relationship between mother and fœtus, which does not permit the direct interchange of blood-corpuscles, and upon the probable fact that the contagium of syphilis is carried only by the blood-corpuscles and not by the serum, so that theoretically the transmission of the disease through the placenta is impossible.

The problem of infection of the fœtus during intra-uterine life simplifies itself into the question whether pathogenic microbes may be transferred from the mother to the fœtus or not. So far as analogy is concerned, different conclusions have been reached by different investigators. The latest opinion on this subject was to the effect that the microbes of pneumonia and typhoid fever, and also the *Bacterium coli commune*, pass the placenta and attack the fœtus *in utero*. Exceptionally, in small-pox, the child born of a mother who has had small-pox during her pregnancy showed signs that the disease has passed through the placenta and reached the fœtus; again, other children of mothers who have had small-pox during their pregnancy are affected in such a way as to be insusceptible to vaccination. We are justified in saying that the microbes of certain diseases pass the placenta to infect the fœtus, and hence we may infer that intra-uterine infection is not impossible in syphilis.

To establish the fact that the mother has acquired syphilis during pregnancy and transmitted it to her fœtus, Taylor (in the recent edition of his work) lays down a series of propositions which must be proved before the fact of such transmission can be accepted: 1. It must be shown that the father was free from syphilis at the time of conception. 2. The infection of the mother during pregnancy and her freedom from the disease previously must be proved beyond doubt. 3. The child must have unmistakable lesions acquired without doubt before birth.

Dr. Post then reported the following case, which he regarded as one of post-conceptional syphilis: Mrs. ——; menstruated last on April 7, 1892. She came under his observation on November 15, 1892, that being the seventh month of her pregnancy. An examination showed sores on the labia, the nature of which he could not positively determine. Shortly before her confinement, which occurred on January 7, 1893, she developed a general papular eruption which made the diagnosis of syphilis absolute. The child at birth was quite free from any lesions, but at the end of a week he was covered with a general syphilitic maculo-papular eruption. He soon lost weight and strength, developed snuffles, cried incessantly, and seemed likely to die. On the evening when the baby seemed sickest, the father, whom Dr. Post had never seen before, but who had asserted that his wife gave him "a disease," met the doctor and confessed that he had acquired syphilis during his wife's pregnancy and infected her. No examination of the father was made. Under mercury the child rapidly improved. Regarding the above case, the following facts were observed by two physicians: The previous good health of the mother was known; the primary sore was seen during the seventh month of the mother's pregnancy; the secondary eruption occurred at about the average time and was in full bloom at the time of delivery, two months later; the child was born apparently healthy, or at least without skin lesions, but a perfectly characteristic eruption and accompanying snuffles showed itself at the end of a week; the father accused his wife of having

given him the disease when she first showed her local lesions, but afterward confessed that he had acquired the disease outside of marital relations and transmitted it to his wife. The only point where the evidence is assailable is the failure to examine the father as to the truth of his story.

Dr. Post reported three other cases where syphilis of the child was thought to be due to inoculation of the mother during the course of her pregnancy, in each case by the father, who acquired the disease after conception had taken place.

DR. R. W. TAYLOR, of New York, said he had been greatly interested in the report of Dr. Post's cases, and the careful, thorough, and yet conservative manner in which this subject had been treated. The author, in his paper, assumed that syphilis is a bacterial disease, and while analogous evidence strongly points to such an ætiology, yet true scientific evidence to that effect is lacking. While by analogy we know a great deal more about syphilis and syphilitic infection to-day than we did years ago, there are still many gaps to be filled. The placenta, as a rule, is a good filter, preventing the transmission of the red blood-corpuscles, which seem to be the vehicles of the disease, but if this is so, why have the microbes of syphilis not been found in them? Women who are infected with syphilis during the first few weeks of pregnancy, usually give birth toward the end of the fourth or fifth month, or perhaps later, to a macerated fœtus. When the infection occurs after the fourth or fifth month they may give birth to either a macerated fœtus or a puny, miserable child which at birth shows no evidence of the disease. Admitting that syphilis is due to a microbe which resides in the red blood-corpuscles and is prevented from coming in contact with the fœtus by the placenta, there is nothing to prevent the constant interchange of serum between mother and fœtus, and this carries with it the toxines of the disease. In the first case reported by Dr. Post it is a matter of regret that he did not give the father a thorough examination to prove the truth of his statements. Assuming that the father's story was true and that this was a reliable case of post-conceptional syphilis, it is probably to be attributed to the fact that the placenta of that mother was not competent: that in the utero-placental circulation, owing to a rupture or thrombosis or some other lesion, there was an interchange of red blood-corpuscles and true syphilitic infection of the fœtus.

DR. P. A. MORROW, of New York, said he had listened to Dr. Post's paper with a great deal of interest. The bacteriological evidence of the communication of other diseases through the utero-placental circulation brought forward in the paper was certainly most interesting, but he did not attach much importance to it in settling the vexed question of post-conceptional syphilis. The clinical cases, however, were so carefully watched and so accurately reported that he regarded them of great value. The speaker said he had always accepted the theory that syphilis of the mother, acquired after conception, may be communicated to the fœtus,

and also that the disease may be communicated to the mother by a syphilitic fœtus. He had observed a number of cases where the wife was inoculated during pregnancy by a syphilitic husband, who had contracted the disease after procreation, resulting in an offspring with unmistakable evidences of syphilis. The theory that the placenta acts as an absolute filter, preventing contact of the syphilitic virus with the fœtus, did not, in his opinion, rest on sufficient evidence. He believed that almost all authorities at the present day recognized that the mother may receive infection from a syphilitic fœtus, and that the mother, healthy at the date of conception, may afterward contract syphilis and communicate it to her child *in utero*.

The chief point in connection with this subject which it was desirable to establish was the period of pregnancy during which this infection of the fœtus through the utero-placental circulation was possible. It was difficult to generalize or establish definite data upon this point. The theory generally accepted was that if the mother acquired syphilis after the sixth month, the product of conception was not liable to become infected. This theory was enunciated by Ricord as far back as 1847, and has since been generally regarded as correct, but if we search the literature, especially the more recent literature of syphilis, we will find quite a number of cases where the mother contracted syphilis as late as the seventh or even the eighth month of her pregnancy and gave birth to an infected fœtus.

Dr. White said there could be no doubt that the placenta acts as a filter. This has been shown experimentally in animals by throwing into the circulation of the pregnant female an insoluble pigment which was retained and did not pass the placenta. Whatever the virus of syphilis may be, we know that the analogy between it and that of other microbic diseases is so close that the evidence in the latter justifies us in drawing conclusions in the former. The speaker expressed the opinion that while the fœtus may be influenced by the toxines of syphilis, even to the point of death, he did not credit the theory that syphilitic manifestations in such a child after birth were due to the toxines alone, the placenta having acted as a competent barrier against the invasion of the bacteria themselves. One reason which may account for the rarity of post-conceptional syphilis probably is that the child, under these circumstances, must undergo a species of vaccination, producing an immunity similar to that observed in the mother, which we know under the name of the law of Colles.

Dr. Sturgis said the interesting point in the first case reported by Dr. Post was that syphilis was conveyed to the infant as late as the seventh month of pregnancy. That point seemed to have been established, no matter what the condition of the father or mother may have been. The speaker said it was by no means certain that a bacterium is the ætiological factor of syphilis, nor had he ever been able to accept the theory that the

placenta acts in the capacity of a filter. He had always supposed that the placenta was the vehicle through which nourishment was conveyed from mother to fœtus. It is well known that certain diseases can be transmitted by the mother to the child *in utero*, which compels us to admit that if the placenta does act as a filter, it is a pretty poor filter, after all.

Dr. Sturgis said that Chabalier, Vajda, and Neumann had reported cases of syphilis where the mother was infected as late as the eighth month, and he expressed the opinion that many similar cases escape notice for the simple reason that it was exceedingly difficult to get an accurate history of such cases. In a pregnant woman the primary lesion was apt to escape notice or might be attributed to some irritation.

DR. POST, in closing the discussion, said that while it must be admitted that theoretically the placenta acted as a filter, yet there were certain facts which went to show that the bacteria of some contagious diseases, at least, may pass through it. We were therefore unable to say whether the virus of syphilis could pass through it or not. The best way to solve the question was by clinical observation. If all such cases coming under the observation of the members were closely studied and carefully followed up, sufficient data would be gathered in a single year to throw much light upon the subject. To make such a plea for closer observation was one of the chief objects of his paper.

Two Cases of Urethral Chancre with Unusual Secondary Symptoms.—By DR. J. P. TUTTLE, of New York. The first case reported was that of a male who for about a week previous to the time when he came under the speaker's observation noticed a slight discharge from the urethra. The discharge was not at all ropy in character; the meatus was not swollen. The urethral wall was hardened and there was slight pain on pressure. The glands in both groins were enlarged. Inspection showed a well-defined ulcer situated about three quarters of an inch back from the meatus; its edges were well marked. As far as could be made out, the lesion seemed to present all the characteristics of a chancre. About ten days later the patient complained of general malaise, his temperature rose to 104° F., and he developed an eruption almost typical of measles, excepting that it was largely confined to the trunk and upper extremities, and that it had the copper-colored tinge suggestive of syphilis. There were no throat symptoms; no bronchial irritation. Later, distinct mucous patches appeared on both tonsils. The eruption lasted about two weeks. The patient improved under specific treatment.

The second case reported was that of a man, aged thirty-five years, who gave a history of numerous attacks of gonorrhœa and stricture. He had intercourse with a prostitute on October 30th last, and two weeks later he was troubled by a slight itching at the meatus, together with a thin, scanty discharge. There was little or no pain on micturition. About half an inch back from the meatus there was an induration of the urethra which could be plainly outlined by palpation. Inspection showed a typical

chancre, crater-shaped, involving about one half the circumference of the urethra. The inguinal glands on one side were swollen and sore; no suppuration. At this time the patient suffered from muscular pains in the arms, worse at night. These were so severe that hypodermic injections of morphine were necessary. On February 23d mucous patches appeared on the left tonsil and a macular eruption could be made out on the trunk. The patient developed an endocarditis and subsequently a cervical meningitis and periostitis, from the effects of which he had not yet recovered. Dr. Tuttle said he was still in doubt as to whether the muscular pains and the cardiac and spinal symptoms were specific in origin or were due to rheumatism or some other constitutional diathesis.

Clinical and Pathological Notes on Syphilis.*—By Dr. J. A. Fordyce, of New York.

Dr. Taylor said that Dr. Fordyce's work in the pathology of syphilitic lesions, as well as his description of the muscular lesions of syphilis, were entirely in accord with our classical knowledge of the disease. The clinical cases reported, particularly the case of brain syphilis, were very interesting. The latter might be considered as tolerably representative of this class of cases, and it strikingly showed the effect of potassium iodide, which was in some instances wonderful.

Dr. Post said he was particularly interested in the cases of syphilitic myositis reported by Dr. Fordyce. During the past year he had seen two or three cases of this character which clinically might be syphilitic, but which occurred in individuals in whom no history of that disease was obtainable, nor were there any other symptoms pointing to it.

Clinical and Pathological Report of a Case of Cerebral Syphilis.†—By Dr. George E. Brewer and Dr. Pearce Bailey, of New York.

Dr. Bailey, in discussing the paper, referred to the rarity of cases of acute cerebral syphilis which afford an opportunity for pathological investigation. At the Workhouse on Blackwell's Island, among the inmates of which syphilis is very common, acute cerebral syphilis is rare and few cases result fatally. The pathology of cerebral syphilis shows that the blood-vessels are the most common seat of the lesions in fatal cases. It is not definitely known in which coat of the vessel the morbid process begins, but the intima shows the most marked changes. It was impossible to distinguish, histologically, between specific endarteritis and endarteritis due to atheroma. The prognosis of acute cerebral syphilis depends upon the predominating anatomical character of the inflammation. The prognosis should always be guarded, especially so in cases which indicate by their symptoms (apoplectiform attacks) involvement of the blood-vessels.

Dr. Fuller referred to a case which recently came under his observation, that of an old sea captain who contracted syphilis three or four years

* Will be published.

† See page 338.

ago. At times he drank heavily. He complained of severe frontal headache, and in spite of all treatment became delirious and died. At the autopsy the gross appearance of the brain was that of a pachymeningitis.

DR. TAYLOR complimented the authors of the paper upon the thorough manner in which the case had been studied and reported.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

New Researches on Alopecia Areata.—The great scientific event of the day in France is, without a doubt, from a dermatological point of view, the publication of Dr. Sabouraud's new researches on alopecia areata. For more than two years without cessation he has pursued a series of histological, micro-biological, experimental, clinical, and therapeutical studies on the subject, and has arrived at results which are most interesting. He has studied three hundred patients, made sixteen biopsies, examined twenty-two pieces taken from a subject dead of tuberculosis, and tried an incalculable number of cultures.

Alopecia Areata a Contagious Disease.—He starts out from the point of view that alopecia areata is a contagious affection. It is the old French theory, that of Bazin, which has been advanced successively by Vidal, Brocq, and Besnier after him. Sabouraud dwells on the facts of contagion of the disease which have been observed by these authors, on the epidemics, and he thinks that the implements of the hairdresser are almost the only agents of transmission of contagion, doubtless because they alone can cause the abrasions necessary for sowing the contagion with which they are contaminated. It is thus explained why alopecia areata seems at first sight to be a sporadic affection in cities, and why in colleges and barracks it may take the shape of an epidemic. Every disease propagated from one individual to another supposes an active cause capable of multiplication and reproduction—that is to say, a living, pathogenic being in the affection, otherwise called a parasite. It is then a question of finding this for alopecia areata.

Some Little-known Peculiarities in the Symptomatology of Alopecia Areata.—Studying deeply the objective symptoms of the disease, Sabouraud insists on this fact, that in an area increasing in size the zone of clubbed hairs is larger and better formed when the extension has been rapid; they are, on the contrary, few and scattered along the border of the patch if it has been slow. The eye can take in at first glance whether the

patches are extending, whether they have terminated their evolution, whether they are more or less active and dangerous. Sometimes, after a period of arrest, the patch begins to increase again; in this case the clubbed hairs return at the periphery which have disappeared during the phase of inaction. This paroxysmal growth is relatively frequent; it is not unusual to see alopecia areata relapse in the same subject, either continually or after intervals of apparent cure of several months or years.

The patch at its outset is characterized objectively by a clear space at the border of which the hairs are already a little less numerous than on neighboring regions. They are shorter and broken at various heights. In the midst of hairs having exactly the appearance, size, and color of normal hair, but of which some are broken in odd lengths, there may be seen a group of clubbed hairs. At the center itself they have already disappeared, leaving their place empty, with the appearance of a follicular opening expanded by sebum or that of the dilated sebaceous pores seen on the nose in acne patients. All around these orifices emptied of their hairs are found other characteristic hairs of the disease implanted *en couronne.*

Summing up, what Dr. Sabouraud calls the embryo of the patch of alopecia areata is composed (1) of one or two orifices at the center, empty and dilated; (2) of four long clubbed hairs disposed in the form of a crown around these orifices.

Study of the Diseased Hair.—Reaching the minute histological study of the hair, the author shows that it is anatomically impossible that the causal microbe should find its place in the clubbed hair, for this hair presents a retrogressive metamorphosis of the adult hair into down. It is therefore the papilla which causes the alteration in the hair, and not a microbe acting on the latter itself. Following the dimensions of the hair, it can be seen that the slow and progressive death of the papilla is completed in fifteen days at the earliest and in two months at the latest. One of the special characteristics of the diseased hair is its friability, transverse and longitudinal, whence its terminal barbing which is so easily broken. Its appearance, however, is eminently variable, and these variabilities correspond with the greater or less rapidity of the process of destruction of the papilla.

When the bacteriology of the hair is taken up, various microbes are found in it. Six are, however, discovered quite constantly. These are (1) a white fungus, (2) a yellow fungus, (3) a bacillus subtiliformis, (4) a bacillus in the form of a boat staining with difficulty, (5) a special micrococcus which Sabouraud designates provisionally under the name of *micrococcus cutis communis,* (6) the spore of Malassez, the flask-bacillus of Unna, which he calls the *bacillus asciformis.* These two microbes, which appear to be the most important, are found in seborrhoics who are not attacked with alopecia areata. No one of these microbes would have the importance of a causal agent in the disease.

Histology of Alopecia Areata.—At the period of regrowth on a patch

which is completely denuded—in other words, when visible cure is about to begin—Sabouraud has found in the skin of the patient these lesions: (1) Many hair follicles have disappeared completely; (2) about those which remain the connective tissue of the derma is gathered into vertical, dense, irregular bundles, beset with connective-tissue cells, some of which contain fat; (3) in the base of these pillars there are a great number of flattened, degenerated cells which are easily recognizable as mast-cells (cells with basophile protoplasmic granules); (4) many hairs are in actual reintegration, and that regrowth is produced in the normal manner common to a noncicatricial alopecia; (5) around the growing hairs the sebaceous glands are already large, some enormous and multilobulated; (6) the pigmentary function is and remains suspended not only in the papillæ of the new hairs, which produces the grayness of the new growth, but also in the basal cells of the epidermis in the whole extent of the patch. This continues to the last period of the cure.

At the time when the hairs have disappeared, the histological examination of the skin shows considerable lesions. There are clusters of migratory cells surrounding each follicle, about one third of which are Ehrlich's mast-cells, the others being almost all mononuclear leucocytes. They are regularly disposed in layers about the vessels. Elsewhere the Malpighian layer is achromic, the cells of the mucous layer present karyokinetic changes, and young lobulated and distorted follicles are found.

In this stage, then, we find no histological lesion pointing expressly to an actual microbic infection. These lesions point, on the contrary, to a profound local intoxication, and one whose cause has already passed away, for we see the phenomena of cellular repurgation, and certain functions which, like the production of hair, were suspended, are partially re-established.

Study of the First Histological Phase of Alopecia Areata. Microbic Period.—When serial sections of the affected scalp are made presenting the lesions at the outset of the disease, lymphocytes and mast-cells are found, but these elements are less numerous than at the center of the patches when complete denudation has been accomplished. The mast-cells are less broken, more globular, and younger; the lymphocytes have a more irregular distribution, less systematized about the vascular tracts. Besides, there are a multitude of young follicles showing the greatest deformities, folds, indentations, partial invaginations, and in these new follicles no new hair is formed even above the young papillæ.

The capital lesion of this stage consists of the formation at the upper third of the follicles, between the sebaceous gland opening and the follicular orifice in the skin, of an ampullalike dilatation about three tenths of a millimetre wide by one half millimetre in height. The habitual form of this dilatation is an ovoid with its long axis vertical. The external follicular orifice has preserved its habitual dimensions, so that this peladic utricle, as Sabouraud calls it, communicates with the exterior

only through a narrow neck. Laterally, it is limited by the wall of the follicle, but the mucous body, its covering, is thinned and atrophied, so that its superposed layers, of which the basal should be formed of cylindrical cells, have scarcely more thickness than the superficial flattened layers. The base of the cavity is rounded or slightly conical. Immediately below it the excretory duct of the sebaceous gland and the follicular canal meet.

When the earliest, the initial stage of the affection is studied, although there are, so to speak, no dermic lesions as yet, no migratory cells about the vessels, no perifollicular infiltrations, the peladic utricle is present, but closed by the horny epidermic layer which passes above and covers it, consisting of strata of epidermic cells containing in their center, like a larva in its cocoon, compact collections of microbes, invariably pure cultures of a microbacillus which is always the same.

Study of the Bacillus of the Peladic Utricle.—The microbacillus is ten times smaller than the short bacillus of diphtheria, shorter and finer than Pfeiffer's influenza bacillus. It is, according to Sabouraud, the smallest of known bacilli. Its early forms are past measurement; they may be one third or one fifth μ. Their longitudinal is scarcely greater than their transverse diameter; they resemble cocci. Older forms, clearly bacillary, often comma-shaped, are one quarter μ in breadth by one half or one μ in length. The young generation is often expanded at the center like a barrel; the same dilatation of the bacillary body exists, but less appreciable, in the adult forms. Its extremities are blunt.

In the utricle, this microbacillus is not ordinarily agminated in chains. It is met with sometimes in the shape of a diplobacillus, more exceptionally in chains of three or four, but in all extensive and severe cases of alopecia areata where the height of the utricle is almost doubled, the streptobacillary forms in sinuous ribbons become the rule in the deeper portions of the utricle. To give the bacillus its true dimensions, it must be stained with thionine. Staining with gentian violet increases both the diameters by coloring the capsule. In each utricle they are so many that Sabouraud thinks they would number millions. They occupy the center of the utricle, and are there contained in polyhedral pockets which they fill and which have the histochemical reactions of horny epidermis.

To make an extemporaneous preparation of this bacillus, it is necessary to look for a beginning patch, still incompletely denuded. Then epilate with great care completely the whole region covered with affected hairs and a zone of healthy hairs outside of them. That done, apply over the surface pure glacial acetic acid and wait until the next day or day after. Then the caustic liquid will have caused a spontaneous exfoliation of the horny layer. Cover the whole region epilated the day before with collodion medicated with castor oil to the thickness of half a millimetre. Wait until it dries, then, raising it by one of its edges, lift it off very slowly. Thus, by a true epilation, the utricles whose neck is adherent to the cir-

cumfollicular epidermic layer will be drawn out. Then, examining the lower side of the collodion, it will be found studded with little villosities; some are constituted of epidermic fragments from the follicular infundibulum, the larger visible to the naked eye or small glass. Detach two or three of these with a knife, place on a slide, crush them between two slides so as to divide them into small particles; wash two or three times with ether to dissolve and remove the fat, stain with gentian violet (a quarter of an hour), decolorize by Gram-Weigert, and examine with an immersion lens (one-sixteenth objective). The bacilli will be seen by millions. (This entire little operation is very delicate, and Sabouraud warns us that much care and patience are necessary to carry it through successfully.)

The procedure can be simplified, for, with practice, the orifice of a hair follicle containing a utricle can be distinguished by the eye and it can sometimes be pressed out by simple pinching. In the beard, epilate slowly one by one the hairs which border the patch on the side where it is advancing; some bring with them to their point of emergence a minute foreign body one tenth the size of a lentil. This little protuberance is a torn fragment of the utricle. This tissue obtained with it will show the bacillus by thousands. However, in certain cases, the utricle can be found only by biopsy in histological sections.

Finally, repeated local applications of glacial acetic acid may be made on a spot until blisters are raised; let the consecutive crust dry until its borders are spontaneously detached, separate and remove it. On the lower surface will be found all the peladic utricles of the region.

Pathogenic Theory of Alopecia Areata.—In the histological process which characterizes the disease, everything takes place as if the pathogenic agent were the minute bacilli already described. Wherever activity persists, and especially where the affection spreads, near the hairs the utricle and its microbe are found. The examination is much more easy when the activity of the lesion is pointed out by a wide zone of fragile hairs. It is about the utricle that the cellular lesions of the disease begin, that the normal hairs atrophy progressively and become the broken ones of the affection. All the characteristic lesions supervene on the disappearance of the utricle around and below it in a very limited area, and these lesions are without exception attributable to phenomena of intoxication. They are atrophy of the hairs, death or inhibition of the papillæ which reform them, the appearance about the vessels of cell masses consisting of lymphocytes and mast-cells, etc. These lesions, rapidly brought into being, are slowly repaired during the bald stage proper of the disease.

If the causal value of the microbacillus of the peladic utricle is admitted, all the clinical facts of medical practice are explained: the utility of the border of epilation circumscribing the diseased patches, the necessity of general antisepsis of the scalp which has remained exempt, the uselessness and inefficiency of antiseptic agents in the cure of the bald

area, the utility of local revulsives favoring the elimination by diapedesis of the toxines.

Unhappily, complete proof (according to Pasteur) of the pathogenic rôle of the microbacillus of the utricle has not yet been found. Dr. Sabouraud has not yet made a culture of it, a positive inoculation, nor a retroculture. He also expresses his doubts with the greatest good faith of its real importance. He remarks that his bacillus resembles almost absolutely the microbe of comedo, of acne, and of seborrhœa of Unna-Hodara. The microbacillus of the peladic utricle is perhaps a little smaller, a little less regular in form, often curved inward; that of comedo is somewhat greater in all dimensions, more regular in form, flatter in appearance, not comma-shaped. Still, these are not sufficiently clear differences to distinguish perfectly between the two. In spite of all the probabilities which result from this study, there remains a haunting doubt of the pathogenic value of the microbacillus of the peladic utricle.

Alopeciæ Decalvantes.—We must add that this doubt persists in the mind of the reader as he peruses Sabouraud's interesting paper on alopecia decalvans—an article of which we can not, for want of space, give a sufficiently detailed account. The author finds in that the same histological lesions as in the common forms, but that which especially predominates is a considerable hypertrophy of the sebaceous glands which form an enormous mass in a sclerosed derma.

From a symptomatic point of view, Sabouraud divides these alopecias into a chronic, complete variety with a greasy skin, in which the integument is spongy and which is particularly severe, and a chronic, complete kind with dry skin, in which the prognosis is much less bad. In recent cases all the follicles show colonies of the microbacillus of the peladic utricle; in the old and greasy alopecias there is not an agglomeration of follicles which does not show at least one infected follicle; in the dry, only one bacillary colony is found in three or four follicular groups. Accordingly, with Sabouraud, one is led to question seriously whether the microbacillus of the utricle and the comedo bacillus of Unna-Hodara are one and the same. If it is so, why does that secondary infection exist at the outset of every alopecia areata and what is its rôle? If, on the contrary, these are two different organisms, they must be differentiated absolutely in order to prove the pathogenic part played in alopecia areata by this bacillus.

There is still another possible hypothesis which the author formulates. The same bacillus, according to different vital conditions, might or might not secrete a pathogenic toxine. This toxine in this case must be isolated. In any hypothesis, he adds, in closing, the study of that microbic species is necessary because, specific or not, it appears constantly and alone in alopecia areata at the precise points and at the very moment when clinical observation and histology show that the disease is active.

We have no need to remark to our readers the capital importance of the series of papers we have just reviewed much too succinctly. The question of alopecia areata has never been studied with such perseverance, such method, and the results already obtained throw a new light on this obscure point of cutaneous pathology. L. BROCQ.

Paris, June 29, 1896.

Selections.

Ulcerative Endocarditis due to the Gonococcus: Gonorrhœal Septicæmia. W. S. THAYER and GEORGE BLUMER (*Johns Hopkins Hospital Bulletin*, No. 61, April, 1896).

The patient died of an acute ulcerative endocarditis, no gonorrhœa having been found in life. Bacteriological examinations from the mitral valve showed gonococci, as did specimens from vagina and uterus. During life, cultures were made from the blood by Littman's method on various media. An apparently pure culture of a biscuit-shaped diplococcus resulted in two of four attempts, but all efforts at transplantation were futile. A negative result followed an attempt at culture at autopsy and the colonies of cocci on the plates were found to be identical morphologically with those taken from the valve thrombi. The mixture on the plates was at least one third blood, so that the medium differed in reality from that advised by Wertheim. Transplantation from this to ordinary media was without result.

The authors believe the organism was the gonococcus because (*a*) of its characteristic form and arrangement, (*b*) its presence in leucocytes, (*c*) its refusal to grow on ordinary media, (*d*) its growth on a mixture of human blood and agar, and (*e*) its decolorization by Gram's method. Two other cases have been reported by Dauber and Borst and by Michaelis. A second case has occurred in the Johns Hopkins Hospital in which three pure cultures were made from the blood. J. C. J.

Pathogenic Classification of Skin Diseases. LEREDDE (*Annales de derm. et de syph.*, t. vii, No. 6, p. 802).

The author proposes the following classification, illustrating each division by examples, fitting them in some cases with difficulty, as may be imagined:

- Primitive affections:
 - Traumatic.
 - Parasitic.
- Secondary affections:
 - (1) Functional disturbances:
 - Of nervous origin.
 - Of blood origin.
 - (2) Dermatoses:
 - Of nervous origin.
 - Of blood origin.
- Malformations.
- Neoplasms.

JOURNAL OF
CUTANEOUS AND GENITO-URINARY
DISEASES.

VOL. XIV. OCTOBER, 1896. No. 10.

Original Communications.

A CASE OF "POROKERATOSIS" (MIBELLI).

BY M. B. HUTCHINS, M. D.,
Clinical Lecturer on Dermatology and Syphilography, Atlanta Medical College, Atlanta, Ga.

THIS case first came under my observation on the 5th day of October, 1892. A description was then written, the diagnosis being left open. I recognized it as dissimilar to any hyperkeratosis with which I was familiar or of which I had read. Fearing that my knowledge of the literature might be incomplete, I hesitated to publish the case.

I did not see Mibelli's report in The International Atlas of Rare Skin Diseases of October 28, 1893, but as soon as I saw his plates and description in the Monatshefte für praktische Dermatologie of November 1, 1893, I recognized the identity of his cases with mine.

My report was further postponed until I should see how his cases were received. Nothing concerning them came to my notice. On January 1, 1894, Respighi's cases were reported in the Monatshefte, after which nothing appeared until March 1, 1895, when Mibelli's second article was published in the same journal.

On May 16, 1895, I succeeded in getting new notes of my case, with two photographs. At intervals up to the present time I have used every effort to get my patient to permit the excision of a portion of the diseased skin for microscopic study; and, after a year of futile effort, I am compelled to report simply the clinical features of the case because of failure to get even the smallest part of the tissue. I hope that the opportunity for a histological examination will yet come.

The first record of my case is as follows:

October 5, 1892.—Mr. W., aged thirty-two years; commercial traveler; wholesale liquors.

The disease began at about the age of two years, just inside of the border of the left palm, at the radial side of the base of the index finger, as a "seed-wart"-like growth. This gradually spread, and other patches, or points, developed until about the age of fifteen, when the one on the palm at the base of the index and middle fingers appeared. He does not know the date or form of development of the dorsal lesions. Now, the original point is the center of a smooth patch of palmlike skin, extending halfway to the base of the metacarpal bone of the first finger on its dorso-radial side, also forward, narrowing, nearly to the first phalangeal joint of the index finger. The patch is irregularly bordered on the radial side of the dorsum of the hand and finger and extends internally nearly on the palm. The boundary of the described area is irregular, wavy, about one line in width and height (two millimetres), and is formed of horny epidermis. It is like the outside of a seam, with a longitudinal, thread-like line dividing its lateral halves. (See diagrams.) Here and there in this line are round, millet-seed, or smaller, sized, blackish epidermic concretions which can be picked out. The "seam" can be cut to the *niveau* without pain or injury to the papillæ. On the dorsum of the first phalanx, external to this "seam," the hairs are broken in their follicles, and the latter show dirty, horny plugs.

On the left palm, corresponding to the lesion which appeared at fifteen, at the base of the first and second fingers, there is a patch the size of a nickel five-cent piece, having the peculiar seamlike border, here scarcely elevated—being more of the nature of a fine fissure. This patch is a smooth hypertrophy of horny epidermis and shows a number of the millet-seed-sized bodies in its surface. Between the radial side of the wrist and the base of the index finger, dorsal surface, is an oblong area surrounded by a "seam" similar to that first described, the included space being an average of one inch wide by two inches long, but the "seam" is tortuous. The skin within looks normal save for one pea-diametered verrucous growth toward its distal end. The hairs in and about the patch are normal. Another patch, similar to the other dorsal ones, lies to the ulnar side of the unaffected surface between the first and third described, about one half by three quarters of an inch in area, included skin normal. The border of all the dorsal patches is markedly seamlike, or like a mole burrow, or a bird's-eye view of a mountain range.

The patient does not remember any recent extension of the disease. There is occasional itching, as upon exposure to the sun.

Just below the left zygoma is a roundish, smooth patch the size of a silver quarter of a dollar, bordered by a fine fringe of internally loosened epidermis. It is of a faintly brownish color, with slight telangiectases and a faintly atrophic appearance. He thinks this lesion is contemporaneous with the lesions on the dorsum of the hand. There are no other lesions.



Fig. 1.

The patient's health is excellent.

As he came to me for treatment, I attempted the removal or destruction of the abdominal growths, first with a twenty-per-cent acid salicylic-flexible-collodion mixture. This took away the excess of horny tissue, but left the thin central line *in statu quo*, save in a point between the two dorsal patches. Fuming nitric acid was afterward penciled on, as a result of which parts of the seam appeared to entirely disappear.

On October 17, 1892, I lost sight of the patient, not examining him again until May 16, 1895.

The description made upon the latter date can be much abbreviated and simplified by a study of the plates (Figs. 1 and 2) which accompany this article, the photographs from which the plates are made having been obtained at that time.

On May 16, 1895, the patch seen between the bases of the index and the middle finger, in the palm, appears slightly horny and shows two or three of the minute plugs or globules (Fig. 1). Its boundary is slightly raised—wavy. Along the free edge of the interdigital fold this border is a very faint, fine seam; the rest of it is more marked and appears composed of two lateral halves divided by a longitudinal, central line of horny tissue of a yellowish or blackish color. The

horny hypertrophy anywhere on the palm is of the usual callous-yellow color. The adjacent part of the patch on the side of the finger and hand is separated from the palmar lesion by a small, horny, epidermic elevation about one eighth of an inch wide.

The boundary of this second patch continues around on the finger and the dorsum of the hand, back to the starting point, as will be seen in an examination of both plates, following the edge of the finger, looping back on its dorsum to the first interosseous muscle and over the edge of the fold between the thumb and index finger (Fig. 2). The



FIG. 2.

"seam" along the dorsum of the finger is the most decided of all, though it is the least distinct in the photograph (Fig. 2). There is a slight break in the "seam" over the middle of the metacarpal bone —on the dorsum. The entire included patch has nothing save a little smoother appearance than the same area on the healthy hand, excepting an epidermic thickening on the dorsal side of and adjacent to the border in the digito-*pollical* fold. The palmar part of this boundary is much like that of the first patch, with here and there within its circumscribed area a few of the minute plugs. The boundary on the dorsal surface is about one twelfth of an inch in thickness, appearing a simple horny hypertrophy—seamlike—with the characteristic

central line, showing many yellowish-black, millet-seed, or smaller sized concretions. The "seam" along the finger may have been increased in thickness by the patient biting there for occasional itching.

Where the "plugs" are absent the "seam" has a simply flattened line in the center, as if a fine thread were laid in.

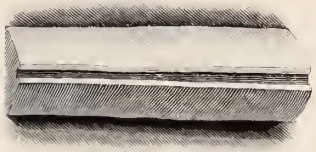


FIG. 3.—Magnified diagrammatic view of a dorsal "seam."



FIG. 4.—Magnified transverse sectional view of dorsal "seam."



FIG. 5.—Magnified transverse sectional view of palmar "seam."

One fourth of an inch to the ulnar side on the dorsum is a dumb-bell-shaped area bounded by the usual "seam," broken for one fourth of an inch in one point, the whole lesion like two half-dime pieces, connected by a small isthmus. This is the patch which was one half by three fourths of an inch in area in October, 1892. It appears to have undergone some mesial change. Between this and the previously mentioned patch is a pinhead-sized horny elevation, doubtless a new lesion. The skin within the last-described patch has a slightly atrophic appearance, but shows a number of normal hairs, one of which is directly in the "seam."

The dorsal metacarpal patch, as seen in the plate, comprises an irregular, tortuously bordered area about one by three inches. Its typical border is connected with patch No. 3 by a horny hypertrophy one fourth of an inch wide. The inclosed skin has the normal appearance, the lesion described in the first notes having disappeared. The hairs are slightly fewer than those without the patch, and some of them are *white*. About an inch from the posterior loop, on the ulnar side, is a pea-diametered widening of the "seam" callouslike. In the "wall" or "seam" are some apparently normal hairs, but there is a keratosis of their follicles, and one or two of them are broken. This, like all the dorsal "seams," has rather pinkish sides, sloping up and inclosing between them the horny thread and a few "plugs." These central formations can be picked out quite easily. The "thread" is distinct and black on the finger.

Save in the *palmar* patches, the round plugs occur only in the center of the "seams."

The disease causes no sensation save an occasional slight itching

in the "seams," especially that of the index finger, exposure to the sun somtimes inducing it. His mother tells him that the disease first appeared in the palm as a " seed wart," which could be picked out.

As to the nerve supply of the regions affected, we find the median in the palm and the radial and part of the ulnar in the dorsum. The disease follows the course of certain parasitic affections rather than the distribution of the nerves.

The face lesion—no photograph of this was obtained—below the anterior extremity of the left zygoma, is oblong, three fourths of an inch across, one inch from the upper to the lower margin in dimensions. It is now faintly brownish, with a tint of red from fine telangiectases, slightly depressed, but non-atrophic to the touch. The lens shows thin, adherent, shining scales. There is no abnormal sensation in the lesion, and I have no information as to absence of secretion.

The patient is of the brunette type, short, robust. His height is five feet seven inches; weight, two hundred and nine pounds. Has gained in weight in the past two years. The general health always good.

In the fall of 1895 he stated that he had carefully watched the hand areas for signs of perspiration and has seen none, though perspiring freely elsewhere. However, the skin, especially in the larger dorsal patch, remains soft and pliant and feels to me a little moist.

Clinically it is presuming somewhat to consider the face lesion as of the same nature as those of the hand; a comparison of the histological structure of all would be necessary to decide this point. I was inclined to consider it only coincident with the others and not as related, but must leave the question *sub judice*, in view of Mibelli's description of his cases.

Changes in the disease of my patient were but slight in over two years and a half. One destroyed dorsal lesion remained away; and possibly the " pinhead lesion " mentioned in the last notes is the only new one. Here and there in the dorsal " seams " is a slight hiatus, whether idiopathic or from my treatment in 1892 it is difficult to decide.

A Comparison of Cases.

V. Mibelli's case (International Atlas of Rare Skin Diseases, October 28, 1893) had lesions on the face and neck; mine only the one on the face to correspond. The face lesion in my case had no marked hyperkeratosic symptom. His " dike " is practically the same as my " seam." There was no peripheral " dike," " wall," or " seam," about

my smallest lesions, save on the palm patch, nor any exaggeration of the process over the joints. His "wide space" on the back of the right hand is similar to the large patches in my case, but mine have no smoother, thinner appearance, and the hairs remain. His "wall" or "dike" showed a tendency to disappear in places; in mine there were, latterly, complete breaks. A little warty lesion on the dorsum in my case is somewhat like his "conical, hard, etc.," elevations. His only palmar lesion was not different from an ordinary callosity. It would be of interest to know if this might develop a condition like the palmar lesion in my case.

His case began at the age of two years, the same as mine, but on the dorsum of the hand—apparently in the same way. The history of the development of mine can not be obtained fully enough for a further comparison. Mibelli's case, in the Atlas, had no subjective symptoms; mine a little itching. No other member of my patient's family had the disease.

In Monatshefte für praktische Dermatologie, Bd. xvii, No. 9, November 1, 1893, Mibelli's article, Beitrag zum Studium der Hypokeratosen der Knaueldrüsengänge—Porokeratosis, is very full and exhaustive, and he has been able to support his views with histological studies from his cases. He also reviews very thoroughly the literature of the hyperkeratoses.

His Tafel vi, Figs. 1 and 3, shows how exactly his cases resemble mine, though it appears that the inclosed areas in his are thinner—atrophic-looking. There are no "disks" in mine which can be compared to his. There was no limiting "seam" or "wall" about the smallest hyperkeratosic lesions in mine. The "grat" in the center of his wall, as well as the little plugs in its middle and elsewhere, are practically the same as mine, but the central thread in mine was not higher than the sides of the seam—generally it was depressed a little.

A comparison as to development in my case is impossible, because the patient does not know, and I have not been able to obtain any information of his mother, who lives in another State. The only information he obtained from her is regarding the original "seed-wart" lesion. The lesions in my case are much fewer than those in Mibelli's, and they appear to have reached quite a fixed state of development.

As in the "Atlas" case, so here I have to say that the hairs persist in my large patches, none in his; his included skin appeared thinner, mine not different from that outside the "seam." The only small

lesion in my case with a peculiar border is the palmar one, so well shown in the plate, with its fine "seam," level, and its longitudinal, blackish-yellow thread and the blackish globules.

A brother of Mibelli's man also had the disease, beginning at eight; a sister, slightly, beginning at two. His Case II—Monatshefte—had lesions on the forehead, face, temple, mastoid region, and neck; also on the extensor surfaces of the forearms, dorsi of the feet and fronts of legs. The "wall" was well marked, also the thin "grat" or ridge. Many of the small lesions had the circumscribing "wall." There were only a few illy developed lesions over the flexors, and his only palmar lesions—on the fingers—were not different from ordinary callosities.

The disease began very late in this case, first on the hairy regions. Case III was much like Case I.

Having no histological specimens from my case, I feel that I am not at all competent to follow Mibelli and Respighi into that part of the subject which deals with the pathology of the disease, save in so far as the clinical features of my case would warrant an opinion. But an opinion under such circumstances can be of little value, and it is best to wait in hope of obtaining material at some future time, with which to study out the pathology of my case and thus get comparisons. My case would not be published even at this late day without the histology if I saw any near prospect of getting specimens, and having to publish it without this necessary part is the source of much regret to me.

Respighi (Monatshefte für praktische Dermatologie, Bd. xviii, No. 2; Ueber eine noch nicht beschriebene Hyperkeratose) mentions five kinds of lesions in his seven cases. His illustrations and descriptions would not alone enable me to identify his cases with mine, though I am able to see a slight resemblance between his and Mibelli's cases. He mentions a special border, but no "dike," "wall," or "seam."

Mibelli (Monatsh. für prak. Derm., Bd. xx, No. 6, Ueber die Porokeratose, neuer Beitrag) says that Respighi's cases are substantially the same as his. This article is mainly an answer to the criticisms of Tommasoli (Comment. clin. d. mal. cut. e gen.-ur., ii. Jahrg., No. 1, 1894). Without having read Tommasoli's article, but with the knowledge of my own case, and with the complete descriptions of Mibelli, I have no hesitation in believing that the former is mistaken in his views, and that he has been perfectly answered by the latter. I think a simple clinical view of the cases would convince Tommasoli

that the process is altogether different from the conditions with which he has endeavored to identify it. The disease is undoubtedly one hitherto unrecognized, having an identity of its own, the clear definement of which we owe to Mibelli.

Mibelli's description of a primary lesion is interesting, but I can not follow him with my case, because there are no lesions which can be positively compared with his as types of the original condition. I agree with him that the "seam," or "wall," composed of two lateral halves separated by a central, longitudinal line, thread, or "grat"—crest—with its horny globules here and there, constitutes the only distinctive and typifying element in the disease. The various lesions of hyperkeratosis, without the bordering "seam," are not characteristic. Absence of hyperæmia or inflammation is a symptom. Figs. 1, 2, and 3, in the last-quoted Monatshefte article, show clearly the appearance of Mibelli's "wall." The central part of mine has less elevation. See diagrams of mine (Figs. 3, 4, and 5). The plaque form, with visible hyperkeratosis within it, and the horny concretions, was present only on the palm in my case, and the limiting "seam" there is non-elevated, simply a fine fissure with its median "thread" and "globules." The normal, extra thickness of the epidermis in the palm would prevent a well-marked elevation of the "seam."

The reader who is interested in following Mibelli's histological studies and his arguments is referred to his articles, which it would be superfluous to introduce here.

The British Journal of Dermatology, November, 1895, has a selection from an article by E. Respighi, Hypokeratosis Eccentrica (Il Jour. ital. del. mal. ven. del. pel., fasc. 1, 1895). The limiting sulcus described doubtless corresponds to the "seam" in the palmar lesions of my case. Respighi says the term "porokeratosis" is too limited. His name describes better the clinical course of the disease, while Mibelli, on the other hand, has constructed a strong chain of histological evidence to support *his* name. In my case some of the hairs were unaffected, some were broken in the follicles, the latter showing horny plugs, and there were also those remarkable white ones. Sweating did seem to be absent in my case, but the large patches remained soft, slightly moist to the touch.

My patient first showed the disease in the *palm*, where there are no hair nor sebaceous gland; so, at least, the hairs and sebaceous glands did not furnish *its* starting point. That the disease began in the sweat glands I have no proof, though it began there if in any appendage of the skin.

The editor who made the last-quoted selection, in the British Journal, is somewhat arbitrary in his objection to a special name for the disease. It is as clearly entitled to a special name as the verrucæ, ichthyosis, keratosis pilaris, pityriasis rubra pilaris, or any other well-defined disease.

As to Mibelli's name for it, it is well justified by his histological discoveries, but further study may necessitate an expansion of the term. All of the epithelial structures are involved in the progress of the lesions, and unless the process is shown definitely and absolutely to begin only in the sweat glands "panokeratosis" or "poro-panokeratosis" must take the place of "porokeratosis."

In the British Journal of Dermatology, February, 1896, another editor appears to have "abstracted" the same article of Respighi, using some different parts of it than are quoted in the November, 1895, issue. The father of the patient had similar lesions. In each quotation the patient is stated to have had the disease for forty years, for thirty years of this time limited to a single patch on the under surface of the left *heel;* other lesions developing in the last ten years. Lesions were on the soles, the palmar surfaces of the fingers, and on the scrotum. It may not be amiss to mention that during the past winter I saw a peculiar, narrow, raised line on the scrotum of a little negro in my clinic, but he disappeared before I could examine it. The description of Respighi's case may have been marred in the translation, or its clearness sacrificed to editorial brevity; but as I get it, it is of no value in identifying the disease as similar to that under consideration.

It only remains to be said, in conclusion, that mine is the only case upon record which has been observed and identified outside of Italy. The records of my case antedate the publication of Mibelli's, but he has the full credit of having worked out the disease and of having been the first to publish his conclusions.

My case is the only one which has typical lesions on the *palm* and which *began* on the palm. One of Respighi's had its beginning on the under surface of the *heel*, but I have not been able to find whether it was a typical lesion. The palmar lesions in several of the cases present, when taken alone, nothing characteristic of the disease.

Much which I might have said at the end of this article has been interspersed among the comments made, in the body of the paper, upon the other cases. It might be repeated that further study is necessary to the final naming of the disease, to decide whether we shall denominate it "porokeratosis," "hyperkeratosis eccentrica," "pano-

keratosis," or "poro-panokeratosis," with or without the adjective "eccentrica."

LITERATURE.

1. International Atlas of Rare Skin Diseases, October 28, 1893.
2. Monatshefte für praktische Dermatologie, Band xvii, No. 9.
3. Monatshefte für praktische Dermatologie, Band xviii, No. 2.
4. Monatshefte für praktische Dermatologie, Band xx, No. 6.
5. The British Journal of Dermatology, November, 1895.
6. The British Journal of Dermatology, February, 1896.

7, 8. Some Italian literature, perhaps, of which I have no knowledge, and a reference in Unna's Histopathologie der Haut.

311 and 312 Fitten Building

AN INTERESTING CASE OF TINEA FAVOSA EPIDERMIDIS.*

BY GROVER WILLIAM WENDE, M. D.,
Instructor of Dermatology, University of Buffalo.

THE subject of tinea favosa has specially interested me by reason of statements frequently made that in this country, where wholesome sanitary conditions among the poorer classes are most easily secured, the disease is of rare occurrence.

We are authoritatively told that the subjects of this disease are mostly children of the lowly, devoid of habits of cleanliness and living without regard to order, who dwell in an environment contaminated by every kind of filth and surrounded by floating organisms, associated with the decomposition and decay of organic matter. We are also told that such unfavorable hygienic conditions not infrequently exist in Poland, Hungary, Scotland, Ireland, Germany, Turkey, Egypt, Algiers, and Morocco, where favus is a common and a formidable malady; that it is exceptional to encounter it in one of American birth; that here at home it is one of the rarest skin diseases.

According to the reports of the American Dermatological Association from 1877 to 1892, there were placed upon record 707 cases of favus out of 205,328 cases of diseases of the skin.

These observations and records, all things considered, are not in

* Case presented before the American Orthopædic Association and the Buffalo Academy of Medicine.

accord with our experience in Buffalo. That favus is most often seen among the poor and filthy we freely admit, but the assertion of its greatest prevalence among foreigners we are inclined to question.

This judgment is based upon the following cases which were seen at the Fitch Provident and University Dispensaries and there treated by my brother, Dr. Ernest Wende, and myself, his numbering 15 and mine 14, making a total of 29, of which cases 22 originated in the United States, 21 being American born. Although Buffalo has an unusually large mixed foreign population, composed of persons who are in the habit of visiting dispensaries for treatment, the number of cases seen among them is few. The following detailed list, giving name and birthplace of patient, is taken from the records in the possession of my brother, with some little commentary of my own:

1. Mrs. Clara Elliot, aged thirty-two years, born in Lancaster, N. Y., has had this disease ever since she was two years old.

2. Robert A. Elliot, aged nine years, born in Buffalo, N. Y., first affected at five years.

3. Albert Elliot, aged seven years, born in Buffalo, N. Y., first attacked at seven months.

4. Frank Elliot, aged five years, born in Buffalo, N. Y., first observed at eighteen months.

(Robert, Albert, and Frank are the sons of Mrs. Clara Elliot. Both their parents and grandparents were born in this country.)

5. George E. E. Pietz, aged five years, born in Buffalo, N. Y., disease began when six months old.

6. Charles E. Pietz, aged four years, born in Buffalo, N. Y., disease showed itself when four months old.

7. William H. Pietz, aged three years, Buffalo, N. Y., disease originated when about sixteen months old.

(The parents and grandparents of these three lads were born in this country.)

8. Charles H. Ahr, twenty-four years of age, born in Buffalo, N. Y.

9. Edward Ahr, aged twenty-two, born in Buffalo. (Both these young men have had the disease from infancy. Parents born in Germany.)

10. Eugene Persons, aged fourteen years, born in Bowmansville, N. Y., has had the disease since early childhood. Parents and grandparents American born.

11. Henry Wakefield, aged eleven years, born in England, but contracted the disease in the United States.

12 and 13. Jacob and Rosa Lubensohn, aged respectively ten and five years, born in Poland, disease imported.

14. Kate Hasse, aged four years, born in Poland, disease imported.

15. Bootblack, who was presented before a medical society some years ago by Dr. Hayd, is undoubtedly an American. Having lost his parents at an early age, was ignorant of his birth and age, but, judging from his appearance and familiarity with local slang, he unquestionably belonged to the United States.

Those which have come under my personal observation may be briefly stated as follows:

1. Abraham Morris, aged eight years, born in Buffalo, N. Y., the disease existing for the past five years.

2. W. Corkhurt, aged ten years, born in Buffalo, N. Y., disease from infancy.

3. Jennie Sakouski, aged eighteen years, born in Italy, disease present from the age of five years.

4. George Sckahen, aged seven years, born in Poland, always had the disease.

5. W. H. Craig, aged twelve years, born in Buffalo, N. Y., disease for four years.

6. Martin Lautz, Jr., aged nine years, born in Buffalo, N. Y., disease present since the age of seven years.

7. Jacob Vinsey, Erie County Hospital, aged eleven years, born in the United States, has always had the disease.

8. Marvin Marks, aged fifteen years, Buffalo, N. Y., disease present since the age of five years.

9 and 10. Rose and Jennie Barro, aged five and seven years, Buffalo, N. Y., disease dates from early childhood.

11. George Rule, aged sixteen years, Buffalo, N. Y., disease for the past twelve years.

12. Frank Toneasellac, aged twenty-two years, Italy, had the disease when he emigrated to this country about thirteen years ago.

13. Leonard Appicella, aged nineteen years, Italy, disease since the age of four, coming to this country the year following.

Another evidence of the prevalence of favus in this country is the frequency with which it occurs in our domesticated animals. I believe that any person properly skilled in diagnosis, who has had a varied experience in the care and treatment of these creatures, can

recall some dog, cat, rabbit, or mouse thus afflicted. On a few occasions I have been consulted by a veterinarian with regard to the treatment of a skin disease in the case of a horse, which he had found



FIG. 1.

more than ordinarily difficult. He was discouraged, and naturally, too, for his patient was suffering from favus.

In the September number of the Journal of Cutaneous and Genito-Urinary Diseases, of 1894, there appeared a digest of fifty-two cases of this disease occurring upon the body, by Dr. Cantrell and Dr. Stout. The cases were carefully described and the article was exhaustive. In eight of these the lesions were extensive, and to this class the following case rightfully belongs. Moreover, I believe it to be one of the severest instances of favus ever recorded. The name of the patient represented in the accompanying illustration is Valentine Vogt, aged twelve years, a native of Buffalo, where he still resides, having always lived in the house where he was born. He is apparently muscular and well nourished, yet his facial expression indicates a condition little short of actual imbecility—a condition mentally dull and slow, largely due, perhaps, to the omission of schooling and discipline. His general appearance, too, reveals a filthy condition in consequence of habitual and persistent neglect.

The first manifestation of the disease, as afforded by the history of this patient, dates back to the time when the unfortunate boy was but two years old. Masses of thickened crusts of a grayish color, and brittle to the touch, superimposed nearly the entire scalp, and just outside of the periphery of this scaly and mortar-plated canopy appeared an occasional yellow incrustation of a circular outline with a depressed center. Pediculi actually swarmed in the matted hair, to which nits were plentifully attached. In places where this crust had become detached the scalp was inflamed and ulcerated or excoriated from vigorous scratching, with the oozing of a bloody serum. Eight irregular bald patches, varying in size from two to twelve centimetres, were easily detected in which the glands and hair follicles had been destroyed, the result of a former invasion. The post-cervical glands were swollen and painful. The head emitted the peculiarly disagreeable odor which characterizes the disease. The whole head was a loathsome vitalized mass.

Anteriorly upon the body, involving mostly the chest, abdomen, and upper portion of the thighs, there existed thirty-eight masses of crusts of all shapes and sizes, grouped and single, with a variation in diameters of one to twelve centimetres. There were also visible twenty-seven well-marked zones of skin which were red, rough, and scaly, pointing out unmistakably localities where the disease once fully flourished, now laid bare by the removal of the crusts, accidentally or otherwise.

Besides these there were conspicuously present numerous parchmentlike scars, the result of atrophic changes and permanent alterations of the skin undoubtedly due to the previous existence of masses of crusts upon these altered spots of the integument.

The entire surface of the circumference of the legs and lower sections of the thighs to the ankles was at one time or another appar-



FIG. 2.

ently involved, as shown by the presence of scars and rough and inflamed zones. One third of the exterior was covered by a mass of confluent crusts that were dirty, disintegrated, and crumbly. However, the features of the crusts were not as characteristically portrayed as they were on other parts of the body.

Ostensibly there were no crusts on the arms, anteriorly, except

one of a mean diameter of about six centimetres which was seated over the biceps, yet history discloses the fact that these surfaces were at one time as universally afflicted as the posterior surfaces are at present, and that it was in this locality that the disease first manifested itself upon the body, which was confirmed by the remains of cicatrices and the prevalence of an efflorescence and scurviness. Of the nails, the little finger of the right hand was the only one afflicted, showing clearly a deposit of fungus beneath it, which was characteristically round and of a beautiful yellow tint. This deposit was evidently of recent origin.

The extensor surfaces were more markedly involved than the flexors. On the right arm, from a point corresponding to the head of the humerus to one opposite the olecranon, almost the whole surface was concealed by a continuous mass of friable crusts measuring twenty-five centimetres in length and varying from five to eight centimetres in width. Upon the forearm there were five distinct crusts with a cross measurement of two to three and a half centimetres. Upon the left arm the lesions were nearly as extensive. Seated over the deltoid, corresponding to the head of the humerus, was a caked mass of crusts having a diameter of about six centimetres. Just below was a similar formation with a measurement not quite as great. In front of these, located well toward the side of the arm, were two parallel lesions having a length of about eight centimetres and a width of nearly three centimetres. Just above the elbow joint was an irregular mass containing some quite characteristic cups. The patch was about eight centimetres in length and four centimetres in width.

The left forearm, like the right, exhibited five lesions with well-marked features. They were single, circular, and measured one centimetre across. Over the trapezius, near its insertion in the acromion and spine of the scapula, the lesion was like the others, a coalescing of crusts, its size being approximately eight to nine centimetres. Extending from this toward the vertebral column was a large, scaly, erythematous area, in size from twelve to eighteen centimetres, which contained several small crusts, and just below this erythematous spot, and to the right of the spinous processes, was found a mass of crusts eight by eleven centimetres and of considerable thickness. (Fig. 1.)

In the right lumbar region was a triangular-shaped mass of crusts of four and a half to five and a half centimetres across, and below this five smaller ones, ranging from one to thirty centimetres, more or less disseminated, and farther down, upon the buttocks, were three very small manifestations, not visible in the illustration, while pos-

teriorly upon the thigh were ten saucer-shaped crusts more or less scattered, the smallest of which was about one centimetre in diameter and the largest two centimetres. Upon the left side of the back, over the scapula, were seated twelve more or less isolated crusts from one to two centimetres in diameter. Below the angle of the scapula, in the direction of the vertebral column, was a group of five lesions, the largest measuring four by seven centimetres, and the smallest about one centimetre. In the gluteal region, located upon an erythematous and scurvy background, were eighteen scutula, of which nine were arranged in a group and nine were diffused. The latter were most characteristic, being of a beautiful yellow color, well formed, shapely, symmetrical, and magnificently round in outline, with elevated border and a central umbilication, as portrayed in illustration No. 2. Their mean diameter was about two centimetres.

Upon the thigh, posteriorly, in an extension of the erythematous patch just mentioned, were three more saucer-shaped crusts, measuring two centimetres in diameter. The total number of scaly and irregular, and likewise erythematous manifestations observed upon the skin of my patient, which were hidden at different times by extensive masses of crusts formed by the coalescing of the favic cups, were fifty-three, of which twenty-six were situated upon the flexor surfaces.

In every instance, upon submitting any of these dry and friable crusts taken from any portion of the body to microscopic examination, they were seen to consist of an admixture of epithelium, pus cells, fat globules, and various *débris* amid which was found that profuse and luxuriant growth, the *Achorion Schönleinii*, composed of an enormous quantity of mycelium, curved, unequally segmented, and at times branched; also an endless number of spores, many free and others joined end to end like strings of beads. These myriads of thin, flat bands, pale gray in color, now and then tinged with green, were branching and inosculating with one another in every direction. Some appeared empty and of simple structure; some were granular, presenting turbid contents; some were constricted, producing a chain of conidia, while others, in a state of fructification, seemed to separate into numerous compartments containing nuclei, thus forming sporophores.

The sporules, generally greenish in color, were in abundance around the meshes of the parent plant, and were small, round, oval, flask or dumb-bell shaped bodies varying in size from six to eight micromillimetres.

SIX CASES OF LABIAL CHANCRE.*

By E. J. STOUT, M. D.,
Philadelphia,
Instructor in Dermatology in the Jefferson Medical College.

THE following cases, six in number, taken from clinical memoranda in the record book of the Dermatological Dispensary of the Jefferson Medical College Hospital, and occurring during a period of eleven months (between April 20, 1895, and April 2, 1896), are illustrations of the not infrequent occurrence of labial chancres. Inasmuch as initial lesions on the lips are not always associated with infiltration—they may be merely fissures—are apt to assume an innocuous and insignificant appearance, and their true nature, were it not for the persistence of the lesion and the supervening symptoms, as adenopathy, cutaneous eruption, etc., is apt to be overlooked, it has occurred to the writer that it might be of interest to give a brief description of the cases.

The first case, a young colored woman, Susan W., aged seventeen years, single, domestic in family, presented herself for treatment April 20, 1895. This patient had a lesion on the left side of the lower lip of three weeks' duration, consisting of a fairly well-defined, indurated, shallow ulcer, almost the size of a five-cent piece, having a raised margin, with but little discharge. Examination showed the submental and submaxillary glands on both sides of the neck to be decidedly enlarged and indurated. This woman developed a characteristic macular eruption and other symptoms of syphilitic infection during the course of the disease. It was impossible to obtain a satisfactory history of the mode of contagion.

The second case came under observation November 15, 1895. The patient, Miss A., unmarried, nineteen years of age, complained of having had sore throat and cephalalgia for some time. Diffused infiltration involving almost the entire lower lip and considerable eversion of that organ were present. This condition had existed about three weeks. The submaxillary glands on both sides were enlarged and of a stony hardness. In addition to the foregoing, a mucous patch was visible laterally on the right side of the tongue near the tip. At

* Read at the Clinical Meeting of the Philadelphia Chapter of the Alumni Association of the Jefferson Medical College, June 1, 1896.

the second visit, three months later, the induration of the lip had disappeared; the submaxillary glands on both sides were still much enlarged and exceedingly hard to the touch. The patient complained of severe pain in the throat; there were present on the head a papulo-pustular eruption and mucous patches around the vagina and anus. A history of the mode of contagion could not be obtained.

Third Case.—John R., single, aged twenty-two years, came under observation November 20, 1895. The initial lesion in this case resembled herpes labialis, was about the size of a marble, and was situated on the right side of the lower lip near the angle of the mouth, and had existed for about three weeks. No other symptoms, with the exception of glandular enlargement in the submaxillary region and some induration at base of lesion, were noticeable at the first visit. At the second visit, about two weeks later, a characteristic, generalized, papular eruption over the body had developed. The patient attributed the lesion to drinking from the same cup previously used by a syphilitic woman, who was employed in the same house. At the expiration of three months the initial lesion had almost entirely disappeared. He had been under treatment with pil. hydrarg. protiodidi, gr. $\frac{1}{4}$, t. i. d., since the appearance of the eruption.

Fourth Case.—John K., married, aged thirty-one years, presented himself for treatment December 17, 1895. In this patient the lesion was the size of a ten-cent piece, circular in shape, and situated on the left side of the lower lip, near the middle, and was of one month's duration. Some induration at its base could be detected with the finger. The lesion was badly defined, not very characteristic, and secreted but little moisture. Enlargement and induration of the submental and submaxillary lymphatics were quite pronounced. Mucous patches at both angles of the mouth, also on tonsils, both sides of uvula and velum palati; the arches of the palate were in an ulcerated condition. He complained of pain, more or less pronounced at times, in lower lip. The patient, after having been under observation for a period of six weeks, had not developed a cutaneous eruption. This might probably be explained by the fact that the man had been under treatment with pil. hydrarg. protiodidi, gr. $\frac{1}{8}$, t. i. d., for a period of three weeks before presenting himself at the clinic, and the cutaneous manifestations had been kept in abeyance by the use of the mercurial. This individual, a man of fair intelligence, after being carefully questioned, attributed the lesion to kissing a woman

with decidedly doubtful antecedents. At the present date (February 3, 1896), ten weeks after its commencement, a shadowy outline of the initial lesion is still traceable on the lip.

Fifth Case.—Lizzie L., white, single, aged nineteen years, presented herself for treatment December 19, 1895. She gave the following history: About six weeks ago she first became aware of the presence of a small papule on the left side of the lower lip, which gradually increased in size, until it reached the dimensions of a five-cent piece. The lesion had slightly elevated margins and a somewhat depressed center; its surface was covered with fine granulations and was slightly moist. The underlying tissues were hard to the touch. The submaxillary glands on both sides were swollen and indurated. She complained of pain of varying severity in the lip. Eight weeks after the advent of the lesion a general macular eruption followed. This girl was placed on hydrarg, protiod. in pill form, in doses of gr. $\frac{1}{8}$, t. i. d., and the eruption improved quite rapidly under this treatment. The lesion on the lip can be still dimly outlined at the present time, twelve weeks after it first appeared. The mode of contagion could not be ascertained, although it is highly probable that the initial lesion was acquired by a kiss. It is perhaps well to add that this case was regarded as a possible lupus vulgaris by an eminent medical authority when brought to the clinic. The history, the rapid development of the lesion, together with the patient's age, rendered this view exceedingly improbable, and later developments, referred to above, proved this opinion to be quite incorrect.

Sixth Case.—F. S., male, aged forty-five years, came to the clinic for treatment April 2, 1896. On the lower lip, exactly in the median line, an ulcer, the size of a ten-cent piece, had existed for three weeks. Induration at the base could be detected with the finger, and the submaxillary glands were found to be enlarged and quite hard to the touch. The ulcer was covered with a pellicle and had the appearance of being coated with collodion and bled quite readily on slight pressure. The edges were somewhat elevated and the lesion was almost perfectly circular in contour. The patient complained of slight pain in the affected area. Mucous patches were nowhere visible in the oral cavity, and a cutaneous eruption had not appeared as yet. The patient, a married man and apparently of sober habits, denied any and all exposure to infection. According to his statement, he had been on business in New York city for a period of three weeks, and during his sojourn in that city had been taking his meals at cheap restaurants on the Bowery. It is possible that in this case domestic

utensils impregnated with syphilitic disease germs were the medium of syphilitic inoculation.

Several instances of mediate syphilitic contagion are recorded on page 43 in Cullerier's Atlas of Venereal Diseases, translated by Bumstead, Philadelphia, 1868. A mother, affected with chancres of the vulva, conveyed syphilis to her three-year-old daughter by washing her with a sponge which she had previously used on her own person. The frequent transmission of syphilis among glass-blowers is referred to (*ibidem*) by means of an iron tube used in their trade, which passes from mouth to mouth, resulting in syphilitic lesions of the mouth. Owing to an epidemic of syphilis resulting from this practice, a law was passed in France compelling each glass-blower to be provided with his own mouthpiece. A highly moral lady (*ibidem*) acquired a labial chancre, followed by syphilis, which was attributed to the patient drinking from the same glass used by a woman who was affected with a labial chancre. The same author quotes the case of a medical man, who contracted a labial chancre in consequence of a careless habit, namely, of holding between his lips the pen used in recording cases, which was soiled by his own fingers after examining syphilitic ulcers. Otis (Syphilis and the Genito-urinary Diseases, page 36, New York, 1891) speaks of pipes used by syphilitics, cigars from syphilitic cigar-makers, pencils, and even sticks of candy, contaminated by syphilitic saliva, as having given rise to inoculation with syphilis. He records (*ibidem*, page 36 *et seq.*) four interesting cases of syphilis acquired undoubtedly through mediate contagion. "One, a young lady, with the initial lesion on the lower lip, acquired from her lover's kiss. The second, a physician, with the initial lesion just within the angle (on the right side) of the mouth, from a syphilitic friend's pipe. The third, in the same locality, appearing, characteristically, about three weeks after a morning spent in a dentist's chair. The fourth, a worthy merchant, with his initial lesion (well marked) on his lower lip, with mucous patches in his mouth, and an accompanying syphilitic iritis. In this latter case the only clew to the mode of acquirement of syphilis was the habit of passing among numerous clerks and occasionally transferring a lead pencil from their desks to his mouth. Well-marked constitutional syphilis, with complete absence of any genital lesion, was present in each case cited." The possibility of syphilitic contagion from smoking cigars, owing to the habit among cigar-makers, who happen to be affected with mucous patches or initial lesions on the labia or in the buccal cavity, of moistening the wrapper with their lips instead of

using mucilage and a brush, has been pointed out. The non-occurrence of syphilis from cigars contaminated in this manner may possibly be due to the fact that the tobacco, being an energetic poison, probably destroys the syphilitic virus. Professor Stelwagon, in his lectures, mentions the case of a gentleman who during his wife's absence was persuaded to visit a house of ill repute. Although he did not indulge in sexual connection, he allowed one of the girls to kiss him on the mouth; several weeks later an initial lesion developed on the lip, which was followed by a subsequent general eruption. For an elaborate treatise relating to mode of syphilitic contagion, the reader is referred to Bulkley's admirable treatise, Syphilis Insontium.

It is apparent from the foregoing that it is of the greatest importance to recognize the true character of extra-genital chancres, especially when situated on the lips and buccal cavity, as soon as possible, as affected individuals, particularly when they hold positions as children's nurses, cooks, domestics, etc., are a source of walking contagion and may do great damage to innocent subjects. Frequently persons who are thus affected are entirely ignorant of the true nature of the disease, having acquired the lesion through kissing. While on this subject I would refer to the almost universal habit—a very deplorable and dangerous one by the way—of allowing children to indulge in promiscuous kissing, especially strangers. It appears indicated to also lay stress on the urgent necessity—bearing the passage from the old poet in mind: *Il n'espargnoit ne couronne ne crosse*—of churchgoers being provided with their own individual communion cups, a subject which has been frequently and with much justice urged in regard to tuberculosis. It is a well-known clinical fact, although not understood by the laity, that contact with a mucous patch always gives rise to an initial lesion on a mucous surface or abrasion, and when one considers the not infrequent occurrence of extra-genital lesions it seems strange that chancres of the lips are not more frequently acquired in public places, as hotels, *cafés*, railroad trains, etc., owing to the same drinking glass and utensils being in general use. The great danger of transmission of syphilitic contagion through the medium of surgical instruments used in the mouth and other situations makes thorough sterilization of all instruments before and after using a *sine qua non* of the conscientious practitioner, and neglect of this precaution can only be regarded as criminal. It is readily understood how difficult it is at times, especially in women, to obtain a reliable history of the mode of contagion. While it is generally believed that contagion, as a rule, is due to contact of the sexual organs

during coition, and is frequently caused by perverted and filthy habits (*modo ferarum*) of sexual intercourse, kissing is not infrequently the mode of contagion. A few remarks relating to the diagnosis of labial chancre seem apropos. The existence of glandular enlargement in the neighborhood of a suspicious lesion is of great diagnostic value and is regarded as being of more importance in establishing a diagnosis than induration of its base. According to the consensus of opinion of syphilographers, glandular enlargement almost invariably, it might be said invariably, makes its appearance three or four weeks after infection, and not infrequently at an earlier date. In very rare cases, according to the old rule, *nulla regula sine exceptione*, induration of the ganglia may not be present. The treatment of the initial lesion and of the disease being so well known, reference in detail to treatment appears superfluous. The use of tobacco in any form where initial lesions or mucous patches exist on the lips, in the buccal or pharyngeal region, should be forbidden, as it proves a source of irritation and retards progress toward recovery.

PHLEGMONOUS INFLAMMATION AND SUPPURATION FOLLOWING VACCINATION—THE VACCINATION ERYSIPELAS OF AUTHORS.*

BY THEODORE W. SCHAEFER, M. D.,
Kansas City, Mo.,
Professor of Dermatology in the Woman's Medical College, Kansas City, Mo.

THE local and constitutional symptoms attendant upon a regular course of vaccine disease are generally of a mild character and pursue a favorable and uneventful termination in the majority of cases. It occasionally happens, however, that the operation of vaccination gives rise to a very violent inflammation that may entail the most serious, if not fatal, consequences.

On perusing the literature of vaccinia one gains but little information in regard to the accidents incidental to vaccination, as most writers do not consider the subject worthy of any great attention, and pass it briefly by with only a few cursory remarks. Struempell, for example, in his otherwise very excellent Text-book on Medicine,

* Read before the Kansas City Academy of Medicine, March 21, 1896.

even goes so far and makes the bold statement that "such misfortunes are extremely rare." That this remark is unwarranted every physician of extensive experience will bear me out. In my sixteen years' experience as physician I have had the opportunity of observing four very violently and dangerously inflamed arms following the operation of vaccination, and know of at least one fatal case occurring in the practice of a medical friend some years ago. We must confess that the operation of vaccination is by no means a trivial affair, and is certainly not devoid of its dangers. No doubt every experienced and observing physician has met with more or less cases in which vaccination was followed by a virulent inflammation of the arm and adjoining parts, the physician doubtless feeling very uneasy and concerned about the final outcome of such an unfortunate accident. Happily this severe kind of inflammatory action pursues a favorable, although somewhat protracted, termination in most cases.

Any abraded surface, being a so-called locus minoris resistentiæ is a favorable culture soil for the localization of pathogenetic microorganisms. In performing the operation of vaccination the physician may accidentally or carelessly infect the scarified parts with pyogenic germs, thus introducing the infectious material directly. Most frequently, however, infection occurs about the time when the vaccine vesicle or pustule is at its height of development. Should at the time of the vesicular stage of vaccinia any slight traumatism occur to the highly succulent tissue, a ready entrance is at once afforded to the ubiquitous pyogenic germs, and the result is a more or less severe local inflammation accompanied by a general systemic disturbance. A diffuse dermatitis spreads around the focus of secondary infection. The arm of the little patient, as the case may be, becomes painful and considerably swollen, the swelling extending from the shoulder down to the elbow, and oftentimes there is an œdema developed from the latter, spreading downward as far as the hand and fingers. The tissues near the site of inoculation become hardened and tumefied; the glands in the axilla are enlarged and tender. The constitutional symptoms manifest themselves in the form of fever, restlessness, and anorexia. Vaccinal eruptions of various forms are apt to develop about this period, appearing at first on the vaccinated arm and later upon the trunk. The erythematous, papular, or even papulo-vesicular rashes are the most frequent. They are of a very short duration, lasting but a few days and then vanish.

The inflammatory phenomena sometimes last two or more weeks before resolution sets in. A necrosed piece of tissue very often marks

the site of inoculation, which slowly sloughs off, leaving a suppurating ulcer, which manifests a very tardy disposition to heal.

The following typical case recently occurred in my practice in this city, and well illustrates the virulence of localized sepsis in cases following vaccination:

Gussie W., aged three years and a half, of fair complexion, son of German-Jewish parents, was vaccinated with bovine virus on an ivory point on November 14, 1895. The vaccine efflorescence pursued its usual period of development until it was noticed to assume an angry-looking appearance on the eleventh day after vaccination. I was called by the anxious parents, and on my arrival found the arm considerably inflamed, swollen, and foreboding trouble. The child was feverish and very restless at night and was troubled with an annoying diarrhœa. The arm was treated at first with moist corrosive sublimate compresses (1 to 1,000), which were later on displaced by a dilute acetate-of-lead solution. The child did not take kindly to medicines, no matter how palatable. As a consequence, the diarrhœal trouble could not be interfered with and lasted nearly two weeks. On the twenty-third day after the vaccination a bright-red macular form of exanthem (roseola vaccina) made its appearance at first on the vaccinated arm, and then became diffused over the whole body and lasted about four days and then disappeared. Synchronous with the evolution of roseola vaccina, a limited vesicular eruption—vaccinola—manifested its appearance in the field of inflammatory action, the number of vesicles not amounting to more than eight. This eruption, also, was of brief duration, lasting only a few days.

For fully two weeks the arm assumed a very threatening appearance, when finally the inflammatory symptoms very gradually subsided, and a necrosed, sloughy piece of tissue, about the size of a quarter of a dollar, remained for some time *in situ* and eventually dropped off, leaving a deep, suppurating ulcer, which was dressed at first with borated vaseline and then with subcarbonate of bismuth to keep the wound dry. As the wound showed such a slow disposition to heal, skin-grafting was suggested, but not accepted, and so the process of repair was entirely left to Nature and ultimately closed by cicatrization on January 25, 1896.

So much for the pathology of vaccination. The physician should be admonished to be very careful in the selection of bovine virus; he should exercise the most scrupulous care and attention as to cleanliness of instruments, and should be pedantic in cleansing the arm before vaccinating; and he should be thoroughly familiar with the

appearances presented by the vaccine disease in its various stages of development.

Accidents will occur, notwithstanding the most diligent obedience to aseptic detail. Physicians are often held responsible for the evil effects which are ascribed to "bad virus"—an unjust accusation. I entertain the conviction that much of the virus as it is sold in the shops is actually worthless and inert, and some, perhaps, is even adulterated with irritating substances, which—like tartar emetic, for example—are capable of producing a deceptive mimicry of cutaneous phenomena similar to those of vaccinia or variola. Now about the treatment. No orthodox or dogmatic line of treatment can be mapped out and blindly followed. As no two cases of the same disease are alike, so must the treatment be also different. The physician must individualize and treat the symptoms as they appear.

The pathology of vaccination is a subject upon which very little has been written by writers on vaccination. There is no doubt that every experienced physician has seen one or more cases of severe localized sepsis following the operation of vaccination; it will be found, on surveying the field, that such accidents are by no means rare, contrary to the statements of the books, as we have been made to believe.

Society Transactions.

THE NEW YORK DERMATOLOGICAL SOCIETY.

Two Hundred and Fifty-third Regular Meeting, held on Tuesday Evening, May 26, 1896.

Dr. C. W. Cutler, *President, in the Chair.*

A Case of Alopecia Areata.—Presented by Dr. Sherwell.

The patient was a married woman, aged twenty-eight years; a native of this country. She was married eight years ago, and had three living children; she had had no miscarriages. Her health had always been good until her last parturition, when she gave birth, somewhat prematurely, to a small, healthy child, which is still alive. Her husband was healthy. During the past year her health had been somewhat impaired, although she complained of nothing but nervousness and occasional at-

tacks of palpation. Dr. Sherwell said this was the same patient whom he presented at the meeting of the society in April, 1895, and a report of the case was published in the Transactions of the society in the October (1895) number of the Journal of Cutaneous and Genito-urinary Diseases. The patient's hair began to fall out in March, 1895, a bald patch, about the size of a silver dollar, first appearing at the vertex. This patch kept increasing in size, and the woman is now almost entirely bald. The hair in the pubic and axillary regions is unaffected.

When the case was first presented there was a difference of opinion among the members present, owing to the acute character and extent of the defluvium capillorum, as to its being syphilitic or not. There was no history of syphilis obtainable, nor has the woman had any acute febrile affection. The lesions have remained unchanged since the case was presented in April, 1895. The patient was an exceedingly susceptible, nervous woman, and Dr. Sherwell said he exhibited her at this time as an example of a true trophoneurotic condition acting as a cause for the circumscribed loss of hair, or, in other words, what he considers an alopecia areata vera, in contradistinction to other forms of circumscribed baldness, for which, in his opinion, another name should be used.

DR. E. B. BRONSON said he regarded the case as a typical one of alopecia areata.

DR. ALLEN and DR. ROBINSON also regarded the case as one of alopecia areata.

DR. CUTLER made the statement that alopecia areata seemed to be unusually prevalent. In his dispensary work he had met with a number of cases during the past month, three of them occurring in the same family.

DR. ALLEN said he had observed a number of cases where patches of alopecia areata seemed to develop in the neighborhood of a scar. He thought this might be due to the fact that such injuries are liable to lessen the vitality of the skin in those regions.

DR. A. R. ROBINSON said that, in order to arrive at the ætiology of these cases, it was important that we limit the term alopecia areata to a condition with definite clinical symptoms and course. In his article in Morrow's System he restricted the term to those cases where the loss of hair began in a small area, which area became larger by peripheral extension. After an injury to a nerve, we might have loss of hair over a triangular or other shaped area; but such cases did not commence as small spots, and later increase in size, nor give the clinical symptoms of the ordinary area Celsus. The latter, in his opinion, was invariably a parasitic disease.

DR. SHERWELL said he agreed with Dr. Robinson that the term alopecia areata should be limited to those cases where the loss of hair is due probably to a trophoneurosis of the affected part. The case presented by him he thought belonged to this category. Of course there

were other alopecias which were circular in outline and extended peripherally which were undoubtedly parasitic in origin.

A Case for Diagnosis.—Presented by Dr. P. A. Morrow for Dr. James C. Johnston.

The patient was a woman, aged fifty-two years, who was born in Ireland and came to this country in 1885. She gave no family or personal history of previous disease. She had had two children, both of whom are living and in good health. Her mother is still alive; her father died of old age at eighty-six. The patient has an eruption which first made its appearance eight years ago. She did not remember that the lesions have ever disappeared since. They first made their appearance on the face, then on the arms and legs. They were at first flat, red, and bled easily. Two years ago the present induration of the skin on the arms began. The lesions became larger, flatter, and harder below the skin. The patient thinks that an attack of what was evidently eczema from irritation was the beginning of present exacerbation. On returning from the seashore two years ago, she had an attack which she likens to "prickly heat"; after various applications the skin became rough, fissured, and finally thickened.

The patient was first seen by Dr. Johnston at the Skin and Cancer Hospital, in May, 1895. He made a diagnosis of herpetiform dermatitis, which, however, he soon abandoned. The appearance of the disease then was the same as at present, excepting that now the papules on the face are less red and prominent. Three lesions have been excised, with a return in every instance. Frightful itching has always marked the process. The woman has received locally antipruritics and internally arsenic in the form of Asiatic pills (arsenious acid, one third grain daily).

Dr. Fox said that when he saw the patient some time ago at the Skin and Cancer Hospital he made a diagnosis of dermatitis herpetiformis. On account of the persistence of the lesions and their doubtful character, he did not think that his original diagnosis was correct, nor did he care to venture a new one. The lesions did not strike him as being malignant in character, and he suggested that their persistence might be due to a fibromatous element. It was possible, he said, that dermatitis herpetiformis might occur in some forms which we have not yet had an opportunity of studying. The case certainly presents some of the subjective symptoms of that disease.

Dr. Allen said that while the case, in his judgment, did not entirely correspond with herpetiform dermatitis, he would class it under that name for the want of more positive knowledge on the subject.

Dr. Klotz said that the case did not seem to belong to any one of the acknowledged diseases of the skin, but he thought it bore more close relations to prurigo than to any other disease.

Clinically, we had the hard nodules, the intense itching, and the long duration, and some chronic thickening of the skin, which represented

the most important symptoms of prurigo, besides a certain resemblance to urticaria in the initial state. But even the microscopical examination had established the existence of vesicles or vacuoles, which reminded one of the cystic cavities found in prurigo and considered characteristic of this disease. He had no doubt that certain French authors, who had widened the term prurigo, would classify this case under that title.

DR. ROBINSON said he was not prepared to make a positive diagnosis, certainly not without a careful microscopic examination. The appearance of the lesions suggested either sarcoma or neurofibroma. The history would probably exclude the former diagnosis, as the lesions have remained about the same size for such a long period.

DR. BRONSON said he did not agree with the statement made by Dr. Klotz that the case resembled one of prurigo. The manifestations were too localized. In prurigo, with lesions of the size of these, the disease would be more general and uniform, and, although we would get papules, we would not expect vesicles of this size. From the grouping of the lesions in this case, and from their general appearance, it corresponded in some respects with dermatitis herpetiformis.

DR. JAMES C. JOHNSTON said he wished to enter a little more fully into the microscopical examination made in this case by Professor Welch, of Baltimore. He said that the pathological condition was one that was new to him. He did not coincide in the view that the case was one of sarcoma cutis. In the epidermis he found marked thickening of the horny layer. Just below the epidermis there is a vesicle, which occupies about one sixth of the total area involved. Below that there are newly formed blood-vessels, with scanty cell infiltration around them. In the lower portion of the corium are these nerve trunks, with small-celled infiltration surrounding them.

In conclusion, Dr. Johnston said the case had excited much interest and discussion, and its true nature was still doubtful. He thought it might safely be called a neurodermatitis.

DR. MORROW, in closing the discussion, said that when he first saw the case with Dr. Johnston, several weeks ago, he was inclined to accept the latter's diagnosis of sarcoma cutis, which, as he understood, was based upon pathological findings. The case, however, did not correspond clinically with any of the types of sarcoma with which he was familiar. In view of Dr. Welch's microscopical investigation, which would contraindicate sarcoma, the speaker said he was completely at sea as to the true nature of the trouble.

A Case of Urticaria Papulosa.—Presented by DR. FOX.

The patient was a boy, with an eruption of three weeks' duration, which was confined principally to the forearms, face, and thighs, with scattered lesions on the trunk. The lesions consisted of firm nodules in the skin, surrounded by an inflammatory halo. The eruption

presented urticarial elements. In appearance it resembled a papular eczema.

Dr. Robinson said he saw the case some time before it came under Dr. Fox's observation. At that time there were a number of lesions on the body that showed a papular condition, with a marked erythematous area outside, like an ordinary urticaria. He regarded the case as one of lichen urticatus.

Dr. Sherwell said he agreed with Dr. Robinson.

Dr. Bronson said the location of the eruption strongly suggested prurigo, which often, in its early stages, had an urticarial form.

Drs. Morrow and Klotz agreed with Dr. Fox that the case was one of urticaria papulosa.

Dr. Allen also regarded the case as one of urticaria papulosa. Cases of this character, he said, might persist for a long time. Sometimes small papules without color will exist underneath the skin and come out as wheals on slight irritation.

Dr. Fox, in closing the discussion, said that, while the appearance and location of the eruption in this case suggested prurigo, there was an absence of that harsh condition of the skin generally met with in that disease, even in areas where there were no papules. The urticarial elements in this case were so marked that the speaker said he preferred the name urticaria papulosa to that of lichen urticatus, as suggested by Dr. Robinson; the latter term, he thought, had been abandoned by many recent writers. Some authorities, Dr. Fox said, claim that urticaria papulosa is more frequent in infancy; personally, he had seen more cases in children than in infants.

A Case of Congenital Nævus.—Presented by Dr. C. W. Cutler.

The case was of interest because of the large size of the nævus and the marked involvement of the lymphatic tissues.

A Case of Mycosis Fungoides in its Erythematous Stage.—Presented by Dr. P. A. Morrow for Dr. B. Lapowski.

The patient was a man, aged forty-nine years; born in Poland. His family history was negative, and he had always enjoyed good health. He denied syphilitic or malarial infection. The patient came to this country twenty-eight years ago, and has never traveled farther than Philadelphia. He was married twenty-three years ago, and has two children, aged, respectively, twenty and twenty-two years. His wife has never had any miscarriages.

Up to October, 1894, the patient enjoyed perfect health. In the latter part of that month, without any apparent cause, his present disease began. Up to this date he has had five attacks, at intervals of four or five months. The following is a description of such an attack: Usually without any apparent cause, sometimes after the depression following financial or domestic troubles, the patient begins to feel an itching sensation between the fingers, accompanied by severe pain in the region

of the left temple, spreading to the spinal column and to the upper and lower extremities. At the same time he feels weak, he loses his desire and ability to follow his work, which is that of a sailor, and is deprived of sleep and appetite. Fever and chills come and go several times daily. These symptoms last three or four days, when he suddenly feels a sensation as though the skin is being pushed outward with the sharp end of a needle, and instantaneously dark-red patches appear in all those locations where the prickling sensation was felt. With the appearance of the patches the fever and chills subside, and a severe burning sensation is felt in the areas occupied by the eruption; this persists for three or four days, reaching its acme at the end of the third or the beginning of the fourth day; at this time his subjective symptoms are very severe, as to his distressing burning sensation an intense itching is added, compelling him to rub his body constantly against some hard object. During this stage it is curious to note that if the patient touches the patches with *his* fingers, the burning sensation is very much increased, and he experiences a feeling which he compares to an electric shock; if, on the other hand, some one else touches the patches, both the burning and itching sensations are greatly relieved. The acme stage does not last longer than a day, and with its disappearance the patches change in color from dark red to *café au lait;* the burning and itching sensations gradually subside, leaving only a slight itching. Thus the whole attack lasts eight or nine days, and by the tenth or eleventh day the patient has entirely recovered. The patches vary in size from that of a palm to a five-cent piece. They have sharply defined borders, and are not raised above the level of the surrounding skin. New patches appear and coalesce with the old, forming large areas of varying form and size. At each subsequent attack new regions of the body become involved. At the present time his entire body, excepting the scalp, face, the lower portions of the limbs, and the soles and palms, is covered with the patches. The lesions do not become raised nor give an urticarial reaction; there is no dermographism. There is slight anæsthesia of the patches, as well as of the apparently sound skin. There is no adenopathy. The hair, nails, and mucous membranes are normal. The urine contains neither albumin nor sugar. The blood has not been examined. Dr. Lapowski regarded the case as one of mycosis fungoides in its erythematous stage.

DR. BRONSON said that he could not, without further observation, accept the diagnosis of mycosis fungoides. There is little change in the skin, and no fungoid development, such as we would expect after the disease had existed for so long a time. The speaker said he had no diagnosis to offer.

DR. SHERWELL said he would not care to venture a diagnosis unless he had an opportunity to examine the patient a number of times, and see him during one of his periodical attacks of erythema. From present

appearances, the case did not impress him as being one of mycosis fungoides.

Dr. Robinson said he had no diagnosis to offer.

Dr. Fox said this was the first case of the kind he had ever seen. He never saw a case of mycosis fungoides in the erythematous stage which resembled this one. From the appearance of the lesions and the history, he felt quite convinced that the case was not one of mycosis fungoides. While the lesions are somewhat suggestive of leprosy, yet other symptoms of that disease are absent.

Dr. Allen said that from present appearances the case suggested, in his judgment, macular leprosy more than anything else. He did not care to venture a positive diagnosis.

Dr. Klotz said he was not ready to accept the diagnosis of mycosis fungoides. The history of the case clearly pointed to some nervous disturbance as the origin of an affection of the skin which resulted in pigmentation, apparently without any other changes of the skin. He wanted to call attention to the fact that similar conditions, only of general distribution, were met with in Addison's disease, which, as far as we knew, was also due to some affection of the suprarenal appendices or other nerve ganglia.

Dr. Lapowski said that Bazin has reported a case of mycosis fungoides in the secondary and tertiary stages, the description of which is exactly like his own, excepting that the pruriginous element was much more pronounced. As regards leprosy, this patient has never been in a locality where that disease develops; he lived in Poland until twenty-eight years ago, and has since then remained in New York.

Dr. Morrow said that, when he examined this patient a few days ago, he was inclined to accept Dr. Lapowski's diagnosis of mycosis fungoides in the erythematous stage, although it did not correspond with that disease, excepting in certain general characteristics of the eruption—that is, the arrangement, contour, and distribution of the patches. It is probable, the speaker said, that we will be obliged to revise our ideas of mycosis fungoides, and accept this case as an illustration of that disease. Dr. Morrow said he had at present two cases of mycosis fungoides under his observation—one he has watched for over two years, and the other for several months—and in both of those cases, although they are somewhat further advanced than this one, there is a constant change in the appearance of the lesions, as if they were in a condition of unrest and mobility. The speaker said he did not think the case was one of macular leprosy, although the lesions closely resembled those of that disease. In leprosy, however, we would, after this length of time, expect certain changes in the nerves and other symptoms which are not present here. In conclusion, Dr. Morrow said he had no positive diagnosis to offer.

Dr. Fox said that in all the cases of mycosis fungoides which he had

had an opportunity to observe in the early stage the patches, in addition to being light in color and scaly, showed a tendency to spread over the surface of the skin, especially about the axillæ and groins, and leave a depressed area in the center, very much as a healing psoriasis will do. In this case the patches are of a different color, and seem to be most deeply marked in the center and faint at the margins.

Book Reviews.

Diseases of the Skin. Volume V, Twentieth Century Practice. Edited by Thomas L. Stedman. New York: William Wood & Co., 1896.

This work is unusual in many of its features, in the good as in the bad. Though it might be expected from the title, it is not and does not pretend to be a complete treatise on dermatology; it is a series of monographs by able representatives of all the present schools on subjects selected without reference to interrelation, and grouped together in the most remarkable scheme of classification it has ever been our fortune to encounter. Simple arrangement in alphabetical order would have been defensible, on the grounds of clearness and usage; but, if classification is to be attempted, it is Hebra's scheme with the modifications introduced by modern pathology that is alone worthy of adoption. Skin affections are oftenest protean in character, and it is worse than useless to place them in papular, squamous, and bullous classes. With the old classification, the work would have worn a far different aspect, and much useless labor in reference would have been saved.

An example or two will serve to show the justice of the criticism. Eczema seborrhoicum is mentioned under parasitic affections, considered under eczema and dermatitis, again under diseases of the sebaceous glands(!). Pemphigus occurs with bullous eruptions and dermatoneuroses. The heterogeneous collection of pustular diseases includes impetigo simplex and herpetiformis, ecthyma, and sycosis. There is no place in the scheme for the hæmorrhages, and, in consequence, peliosis is placed with the erythematous, certain purpuras with the neurotic diseases, while the hæmorrhagic, simple, and senile varieties are left out altogether. Among the more notable of the other omissions are the tuberculoses, syphilis, leprosy, and all the malignant growths, except xeroderma pigmentosum. Semeiology and physiology are also forgotten, but it is to be presumed, from the editor's remark anent leprosy, that many of the omissions will be found in subsequent volumes of the series.

There is one more striking lack which is the fault of the individual

contributor, and that is the small consideration given to pathological anatomy. From cover to cover we found but one reference to Unna's "Histopathology." The distinction is Dr. Allen's. Aside from these objections, the discordant notes in the praise due are few. The reasons for both will appear as the author's work is taken up *ad seriatim*. The book should be found on the shelves of every dermatologist, if for no other reason than that contained in Brocq's article on the Papular Affections.

Dr. Allen opens the volume with a discussion on Anatomy, which is clear and concise. While issue might be taken with him on such minor points as the division of the epidermis, lining of the sweat ducts, and site of the pigment in the colored races, still they are largely a question of individual opinion or preference, and, being such, are hardly worth the raising. Following Duhring, he has adopted Unna's epidermis and root sheath in the nomenclature of the hair follicle, though holding still to the layers of Henle and Huxley in the latter.

Parasitic Diseases receive very full treatment at Bulkley's hands. Several parasites—both animal and vegetable—are here included, which are not usually found in this literature. The consideration of tinea is a good *résumé* on the whole, but the object in establishing a special class for "bald" cases is not apparent. This stage is not infrequently seen in the ordinary course of the disease. The author takes no position between Sabouraud and Leslie Roberts, leaving the case after stating it. His method of epilation with adhesive sticks he still upholds, although it is little short of barbarous cruelty, according to personal observation. The impressions of those of us here who have studied the sections from Dr. Hyde's case of mycetoma are fully in accord with the views which claim an identity between the fungus in this disease and actinomycosis. The microparasitic affections are classified to the best of our knowledge and left to succeeding authors for fuller consideration. Long bibliographical lists are a feature of every contribution.

Dr. Whitehouse has the Erythematous, Bullous, and Pustular Affections allotted to him, and, taking into consideration the handicap of such a classification, acquits himself well. He divides the erythemata into hyperæmic and inflammatory, and among the former describes an erythema intertrigo which he, like others, fails to establish as a clinical entity. The exudation he describes is hardly a symptom of erythema. The multiform variety is of chief interest, and is well done. Erythema urticatum is a papular urticaria, and should be so considered, unless both are denominated angioneuroses—a theory of whose adequacy the author has doubts. White would certainly disagree with him as to the part played by diet both in ætiology and treatment. The numerous cases in immigrants are familiar to many observers. Bullous Affections include pemphigus, hydroa, herpetiform dermatitis, and pompholyx, and is interesting correspondingly. Pemphigus vegetans and acutus are held to be

subvarieties of pemphigus vulgaris. Pernet and Bullock seem to have finally justified the author's expectation of the finding of a bacterium in acute contagious cases. Hydroa vacciniforme is the only one left of the multitude formerly so called. Dermatitis herpetiformis, which in its whole course may never display a bullous lesion, illustrates perhaps better than any other disease the difficulty of fitting this classification to facts. Pompholyx is properly distinguished clearly from dysidrosis. Epidermolysis bullosa deserves more consideration here than mere mention. In Pustular Affections the author fails to make his case with regard to the resurrection of impetigo simplex, especially since he describes ecthyma as a distinct disease. Sycosis, the fifth of this strange group, is admirably done.

Dr. Hyde devotes himself to Eczema and Dermatitis. He describes, diametrically opposed to Kaposi, four elementary, independent forms of eczema. The division into acute and chronic occupies a very secondary place. His treatment of the local varieties is carried out to perfection, but why mar it with the introduction of prickly heat, which Pollitzer has shown to be a sweat-gland disease? Dermatitis medicamentosa is short, consideration being given only to important drugs. Its extraordinary feature is the entire omission, even in connection with quinine, of Morrow's name.

Squamous, Phlegmonous, and Ulcerative Affections fall to Crocker's careful handling. The treatment of psoriasis by salicylic acid, introduced by him, has given good results here. In pityriasis rubra he includes Hebra's and Savill's diseases and Besnier's erythrodermie exfoliante. He treats of three gangrenes, of infants, diabetic and hysterical or spontaneous, with which he places Kaposi's zoster gangrænosus.

Van Harlingen contributes the articles on Diseases of the Sebaceous and Sweat Glands, and the first of the former is seborrhœa. The author, claiming priority in the discovery of the pityriasic nature of seborrhœa sicca, recognizing seborrhœa oleosa as an oily hyperidrosis, as well as the true nature of seborrhœic eczema, nevertheless insists upon grouping them as functional sweat-gland diseases. We think that Unna's and Elliot's claims for microparasites deserve more than a few lines of consideration before the case is dismissed as not proved. Acne necrotica is confusing. It is described as a pilo-sebaceous perifolliculitis following Fordyce, and further on, in the differentiation from hidrosadenitis, a distinction is made between it and acne varioliformis, where none exist. Hidradenitis includes both the phlegmonous form of Verneuil and that of Dubreuilh. There is no mention of the bacillus fœtidus in the ætiology of bromidrosis.

The nails, so much neglected, receive in the work of Montgomery, of San Francisco, fuller and more satisfactory treatment than in any treatise in this language. Many curious hair affections, usually omitted, are also given. In alopecia areata the author leans to the theory of parasitic origin.

Benign Neoplasms, by John T. Bowen, is a long chapter which, on account of the exceeding length of this review, must be lightly touched upon. Bowen insists that xanthoma diabeticorum is to be considered a variety of ordinary xanthoma, and accepts Besnier's mistake of cause for effect, ignoring both Torok and Unna ("Histopathology"), to whom he does not refer. It seems probable that Kaposi classes lupus erythematosus with the atrophies with at least as much reason as Bowen with the benign growths, in view of the fact that its chief feature is inflammation, and its result in a few disseminate cases has been lethal. The vast amount of work gathered here makes the article well adapted for reference.

Kaposi's Xeroderma Pigmentosum, to which a whole chapter is devoted, is a review of his well-known writings on the disease. He pointedly and characteristically remarks that enough has been said on the subject.

Leloir's article on the Dermatoneuroses is a monument to his learning and untiring effort. It is difficult reading, but well repays the mental exertion necessary to its complete comprehension. It seems a presumption to criticize it in any respect, but the conviction forces itself on the reader that the author does not make a clear distinction between *post hoc* and *propter hoc*. The discovery of degeneration in peripheral nerves does not prove their causal relation with a disease of the skin overlying them. This applies, of course, only to a relatively small class of dermatoneuroses. It is hard to give any idea of the magnitude of the work, except to say that it extends over one hundred and fifty pages, and includes all forms of disease, from glossy skin, whose nervous origin is indisputable, to those like ichthyosis and vitiligo, which have a more than doubtful ætiology even in selected cases.

Following the plan of keeping the best to the last, that place is Brocq's. His article on the Papular Affections is a fit supplement to his famous treatise of 1889. If the lichen question is ever definitely settled in our time, it will be by his efforts, and it is a pleasure to see his work in permanent form in clear and smooth English. He says that the causes of error as regards the lichens which lead the creators of the group astray were mistakes in regarding symptoms as characteristic which were really only secondary and inconsequential. These were thickening and infiltration of the skin, quadrilateral markings, fine and adherent desquamation. The article opens with a history of the discussion in which Brocq states that he was stimulated to his part by Unna's and Taylor's monographs and Kaposi's admission regarding the Baretta models of pityriasis rubra pilaris. Brocq's division of the lichens is as follows: (a) Lichen ruber planus (Wilson), (b) lichen ruber obtusus and (c) lichen ruber acuminatus neuroticus (Unna), (d) lichen ruber corneus and (e) lichen ruber planus atrophicus. True lichen planus is the prototype of the group; the others are clinical forms in the same class. Unna's

neurotic lichen, entirely distinct from Kaposi's disease, seems to excite some doubts in the author's mind, but serves well to explain those cases in which eruptive elements of the plane, acuminate and hypertrophic varieties, occur together. The lichen ruber of Hebra-Kaposi is the pityriasis rubra pilaris of "Devergie-Besnier-Richaud," and is distinguished from Unna's lichen neuroticus by the fact of the primary lesion being in the latter a papule, in the former a keratosis. The prurigos are only second in interest to the lichens. They include (a) prurigo Hebræ (ferox and mitis), (b) diathetic prurigos of Besnier, (c) prurigo ferox of Vidal, and (d) Broeq's prurigo simplex. The last is not recognized in this country, to the best of our knowledge; Vidal's disease differs from true prurigo in being characterized by large, red papulo-vesicles. Lichen scrofulosorum is the last article in the chapter.

It seems a pity that the volume can not be purchased separately from its fellows of the "Twentieth Century" series, for it will be invaluable to dermatologists as a work of reference. James C. Johnston.

Manual of Syphilis and the Venereal Diseases. James Nevins Hyde and Frank H. Montgomery. Philadelphia: W. B. Saunders, 1895.

There are other treatises by American authors of recent date which are fuller and more exhaustive than this, but there are few which approach it in clearness, and for thorough adaptation to students' needs it is without a peer in the language. In this field, if the illustrations were good, it would nearly approach perfection. Its consideration includes syphilis; affections dubbed disorders not invariably venereal, which cover balanitis, phimosis, herpes, etc., and whose study is essential for diagnosis; chancroid; urethritis, and its complications, chronic urethritis and stricture. After a brief review of its history, the chancre and the evolution of syphilis, in which it is claimed that the time schedule is better replaced by a division into benignant syphilis with mild and transitory or relapsing and persistent symptoms, and malignant disease with relapsing or profound symptoms which may or may not be ultimately destructive, one by one syphilis of the various organs is taken up, beginning with the skin. Syphilis of the muscles is not clear. That its two forms, interstitial and gummatous, may coexist is certain, but in chronic interstitial forms the cell infiltration is not gummatous. The parasyphilitic affections are not touched upon; the connection of the pigmentary syphilide with them is not mentioned. Treatment is still largely a matter of preference, and the author's claims for the protiodide are supported by many here and in France. The methods by inunction and injection are relegated to a very secondary place, and no mention is made of the extreme efficacy of the latter in late disease of the air passages, for example. The use of Dietrich's ointment removes the objections on cosmetic grounds to inunction. Serum therapy is worthy of some consideration in view of its increasing number of advocates. The efforts to rid us of such compounds as syphi-

litic lupus, lichen, and pemphigus will strike many a chord of ready sympathy.

The position of the bacillus of Ducrey, which is regarded as identical with that of Unna, is held to be still *sub judice*. The chapter on hypochondriasis shows evidence of a sound sense and appreciation of the state of these unfortunates which is often absent in their treatment. The plea for sexual morality in the male is eloquent, but liable to fall on the ears of the deaf. The authors follow Finger's recent utterances closely in the chapters on urethritis, so there is little to criticise. They place their collective foot squarely on the neck of the so-called abortive treatment of gonorrhœa as well as the method by irrigation which is not called by Janet's name. It would be difficult to find a better summing-up of the varied modes of handling this disease than is here presented.

J. C. J.

Syphilis. Alfred Cooper. Second Edition, edited by Edward Cotterell. Philadelphia: P. Blakiston, Son & Co., 1895.

The profession is familiar with this work, the first edition of which appeared in 1884. Numerous additions have been made, rendering the work very fairly representative of modern ideas on the chief points in connection with the disease, but it seems certainly good ground for wonder that a man of the author's attainments should find himself occupying in these latter days the middle place between unicists and dualists, with no belief in the specificity of any "soft venereal ulcer." The bacillus of Ducrey does not exist, so far as this work is concerned. As regards treatment, Mr. Cooper's preference is administration *per os* of pil. hydrargyri pushed to the point of salivation. Illustration in the form of chromolithography is profuse. The majority of the plates are faulty enough to be misleading to students. The half-tones, chiefly of histological preparations, are much better.

J. C. J.

Therapeutic Notes.

Researches upon Serotherapy in Urinary Infection. Albarran and Mosny (*Annales des malad. des organes génito-urin.*, No. 5, 1896; presented in the French Academy of Science by Prof. Guyon).

In certain genito-urinary operations an infection with severe symptoms may be expected beforehand. Bearing in mind not only the therapeutic but also the preventive efficacy of serotherapy, the authors applied the method in septicæmia from *Bacillus coli communis*, and in their ex-

periments they used two hundred and fifty guinea-pigs, forty rabbits, and six dogs.

Three methods of vaccination were employed:

1. Repeated inoculations of living cultures of *Bacillus coli communis.* This method gave satisfactory results only in dogs, which are not very susceptible to the virus, as a dog of eight kilos received one hundred and sixty-five cubic centimetres of virulent cultures without grave results, when a guinea-pig succumbed twelve hours after receiving 0.005 cubic centimetre of the same culture. This method is not entirely satisfactory, since it produces visceral latent suppurations.

2. Inoculations of filtrates from the macerated organs of animals which succumbed to infection with *Bacillus coli communis.* One cubic centimetre of the filtrate protects a guinea-pig from a double mortal dose of a culture injected twenty-four hours after. In rabbits, the results are even more satisfactory.

3. Alternate inoculations with filtrates and virulent cultures. The animals treated by this method can bear without any great reaction considerable doses of very virulent cultures.

The best serum obtainable from a rabbit is by the method of alternate inoculations; from a dog by successive inoculations of virulent cultures. This serum is very active.

The preventive efficacy of the serum is demonstrated by the fact that a mortal dose of the virulent culture, mixed with one drop of that serum, loses its virulent power. The curative value is shown by the fact that a guinea-pig, inoculated with a double mortal dose of the virulent culture, survives if it receives two hours after the infection two cubic centimetres of the curative serum.

As to the effect upon human beings, the authors state that at present they can only say that the injections of the serum were innocuous, promising to publish details and results in the near future. LAPOWSKI.

Cutaneous Tuberculosis Cured by Potassium Cantharidate (*Bull. de la Soc. franc. de derm. et de syph.*, Jan., 1896, p. 40).—Gaston Brant-hommi, after failure of curetting, used injections of a solution containing pot. canthar., 0.001 gramme; cocain. hydrochlor., 0.1; aq. destill., 10. One cubic centimetre was used in each of nine injections, covering a period of three weeks. The injections were painful, causing rise of temperature twice and abscess once. The patch was completely cicatrized in four weeks.

Chromic Acid in Intertrigo (*Bulletins de la Soc. de derm., 1896*).—Brault uses the acid in three-per-cent solution in cases where there is not too much irritation after carefully washing and drying the affected parts. They should be dusted afterward with some inert powder. Two or three applications should be made at three or four days' interval.



A PECULIAR AFFECTION OF THE LIPS.

(Illustrating Dr. Fordyce's Article.)

JOURNAL OF
CUTANEOUS AND GENITO-URINARY
DISEASES.

VOL. XIV. NOVEMBER, 1896. No. 11.

Original Communications.

A PECULIAR AFFECTION OF THE MUCOUS MEMBRANE OF THE LIPS AND ORAL CAVITY.*

BY J. A. FORDYCE, M. D.,

Professor of Dermatology and Syphilology, Bellevue Hospital Medical College; Visiting Dermatologist to the City Hospital, etc.

IN the autumn of 1895 I presented to the New York Dermatological Society † a physician who had consulted me for an affection of the mucous membrane of the lips and oral cavity. The patient's attention was first attracted to the condition about two years ago by a symmetrical fading of the vermilion border of the upper lip, extending from the corners of the mouth almost to the median line, leaving only a narrow margin free next to the skin and a wedge-shaped area in the center of the lip. The two patches were connected at the inferior median line, where the lips come in contact, by a segment of a circle, making three patches, all of uniform color, with well-defined borders and areas slightly elevated. When first noticed the color was but a shade lighter than normal; the appearance otherwise did not seem abnormal, but, by putting the tissues on the stretch, small, irregular, closely aggregated miliumlike bodies of a light yellow color just beneath the surface epithelium were plainly visible and completely covered the patches. (See colored plate.) While the borders appeared as well-defined lines, a chain of from one to three milium bodies could occasionally be seen in advance of the main patch, but not disconnected. The two sides have progressed sym-

* Read at the Twentieth Annual Meeting of the American Dermatological Association, September 8, 1896.

† Two hundred and forty-sixth regular meeting, October, 1895. Journal of Cutaneous and Genito-Urinary Diseases, January, 1896.

metrically. On the lower lip was a parallel line of similar bodies extending horizontally through the center. The patient is unable to state positively whether there has been any extension of the condition since it was first noticed; he is positive, however, that the color has become lighter within the past six months. This he thought might be due to the fact that the bodies have become more closely aggregated. The subjective symptoms have been very slight. The patient experiences at times a slight immobility of the upper lip, which he is inclined to attribute to a dryness just above a nerveless tooth. This feeling preceded the onset of the above condition by several years. Within the past year he has felt a slight burning and itching of the upper lip, accompanied by some stiffness, as though the lip was swollen. This is only an occasional feeling, and may be due to errors of diet. The patient does not use tobacco or alcohol. His family as well as his past history is negative, and he is in good health at present.

An examination of the mucous membrane of the mouth revealed a similar condition extending along the line of the closed teeth from the angle of the mouth backward to a point opposite the lost molar teeth. The lesions within the oral cavity were lighter in color and in places somewhat elevated and papillomatous in character.

On the lips the minute yellowish-white bodies imbedded in the mucous membrane suggested the ordinary milium seen on the face. An endeavor was made to remove them by incising the skin and picking them out with a needle. They were, however, found to be firmly adherent, and could with difficulty be detached from the surrounding tissue.

The lesions were rendered much less noticeable for a time by the use of the curette. When the superficial layer of the epithelium was scraped away, some of the bodies could be pressed out by the blunt edge of the instrument, but as a rule a portion of the discoloration remained, as if only the upper part of the affected tissue had been removed. When the epithelium was restored a marked improvement was noted in the appearance of the lips, but after a few weeks it became less perceptible, gradually assuming the same yellowish-white granular appearance that was present before interference.

Little information was obtained from the members of the society regarding the nature or treatment of this apparently unique affection. Dr. Elliot had observed a similar condition on the mucous surface of the prepuce, and Dr. Bulkley had seen similar lesions on the lips, which he had regarded as akin to milium.

After an examination of some microscopic sections which were

submitted to the members, Dr. Lustgarten agreed with me that the changes were chiefly confined to the epithelial cells, the protoplasm of the cells being apparently converted into a substance allied to keratohyalin, which under normal conditions does not exist in mucous membranes.

Dr. Lustgarten suggested the application of tincture of iodine to the implicated area, on the supposition that the affection was allied to one described by Baelz and Unna. Such applications were subsequently made by the patient, but without a favorable result.

After leaving New York my patient returned to his former home in the South, and wrote to me the following interesting communication:

"I found the same condition, for which I consulted you, in all the members of my family, from the youngest aged seventeen, to the oldest aged forty, including a paternal half sister aged fifty.

"I discovered it in nearly every case examined, existing as a few bodies confined to the lips, to an involvement of both lips and buccal mucous membranes, in individuals who were and in those who were not related. The younger the individual affected, the larger and more grouped were the bodies found to be, involving the inner surface of the upper lip when not found elsewhere. As the affected person grows older, and where there is a family predisposition, as it seems to be worse in some families, the bodies become more numerous, and, judging from their smaller size, undergo atrophy.

"It was not remarked before the age of puberty and existed regardless of sex.

"The same condition prevails, but to a lesser extent, in half the negroes examined. In a mulatto male of seventy years both lips and buccal mucous membranes were implicated. Near the angle of the mouth and extending half the distance backward the membrane presented a smooth opaque surface, somewhat thickened, with three deeply imbedded, slightly elevated papules about half the size of a split pea. Farther back was a pearly epithelial tumor of less size. (This diagnosis was apparently not confirmed by a microscopic examination.)

"He had suffered no annoyance from the affection, although he was accustomed to smoking, chewing, and the use of alcoholic stimulants.

"Some of the persons complain of fissures of their tongues which smart when irritating substances or acids are taken into the mouth.

"In most of the cases seborrhœal eczema was present at the same time."

On returning to his home in the West, he wrote me that the treatment by tincture of iodine had failed to produce any beneficial result. A slight scaly condition of the lips, which was worse in cold weather, had been aggravated by the local application.

"The curetted areas show as much of the epithelial change as elsewhere, but retain more of the normal vermilion color. I have seen a few cases in Oregon, but none so well marked as my own.

"I consulted a number of dentists as to whether they had observed instances of such a condition in the mouth, but received a negative reply to all my inquiries."

Since my attention has been called to the affection by the case of the doctor just reported, I have seen several instances of the same affection in a number of dispensary patients, and several dermatologists have stated to me that they have also observed the same changes on the lips and in the mouth.

I have noted the two following instances in which the mucous membrane lesions were associated with other pathological conditions:

H. P. B., aged forty-seven years. Alopecia and seborrhœal eczema of the scalp, keratosis of the palms. Miliumlike bodies of lips and inner surface of cheeks presenting an almost identical appearance to the case previously reported. The patient was ignorant of the existence of the trouble, as it gave rise to no subjective sensations.

M. R., aged sixty-three years, smoker (pipe), syphilis twenty-five years ago.

In the center of the lower lip an indurated and slightly ulcerated nodule, probably a beginning epithelioma, was noted.

The mucous surface of the lower lip was slightly scaly, and the seat of a number of pale-yellow nodules; the upper lip and buccal mucous membrane were also involved.

No glandular enlargement was present.

The association of a probably beginning epithelioma with this epithelial cell change is suggestive, and should direct attention to the condition of the upper lip in the early stages of the malignant disease. On the skin we know of many pre-epitheliomatous changes in the epidermis, and it is possible that the changes described may bear some relationship to the cancerous process. In Paget's disease it is known that for many years changes exist in the cells of the epidermis, interfering with the normal formation of horny tissue and leading to malignant changes in the mammary-gland epithelium.



FIG. 1

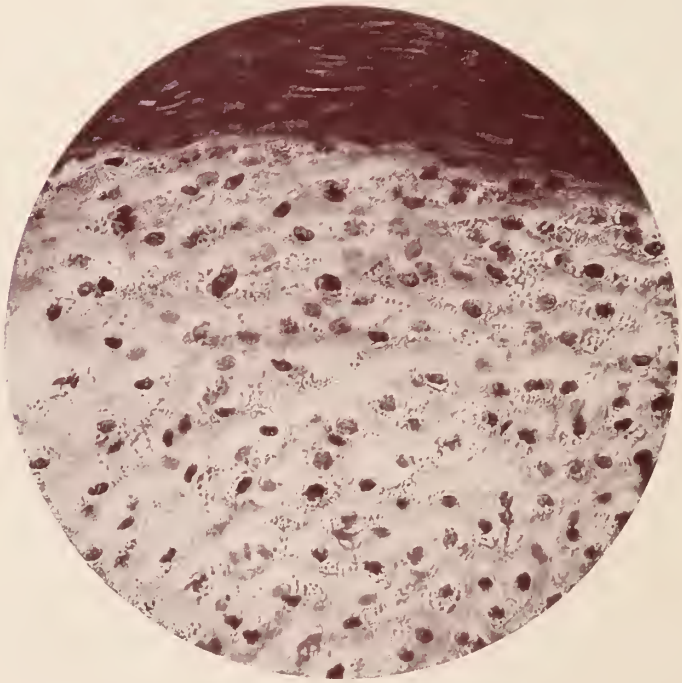


FIG. 2.

ILLUSTRATING DR. FORDYCE'S ARTICLE

(Photomicrograp

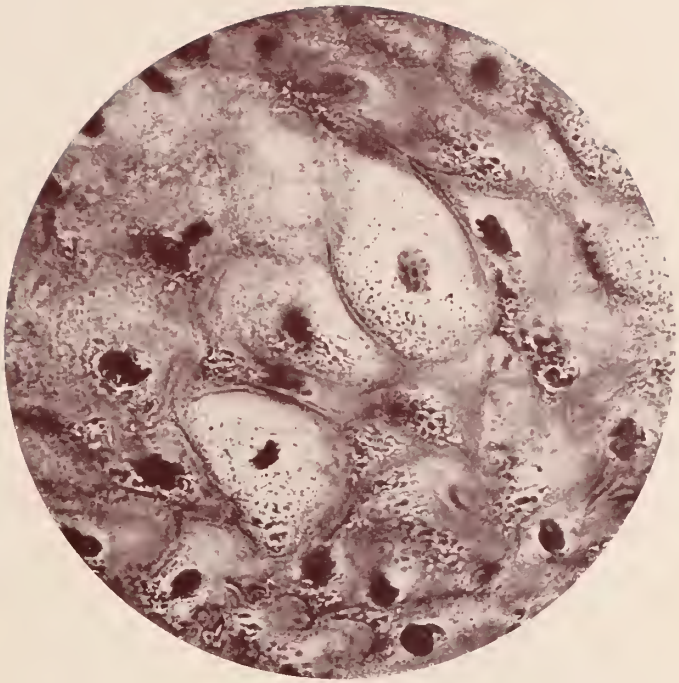


Fig. 3.

Fig. 1.—Section through mucous membrane, showing thickened epithelial layer and stratified surface cells. Spencer $\frac{1}{2}$ in. Projection ocular 2, Zeiss. × 100.

Fig. 2.—A more highly magnified view of a portion of Fig. 1, showing the peculiar change in the cell protoplasm. Spencer $\frac{1}{4}$ in. Projection ocular 2, Zeiss. × 300.

Fig. 3.—A more highly magnified view of a portion of Fig. 2, showing the cell degeneration. Spencer $\frac{1}{10}$ in. Projection ocular 2, Zeiss. × 800.

The infrequency of cancer of the upper lip may be explained on the theory that in smoking less pressure is exerted on this part, and consequently there is less danger of the changed epithelium being stimulated to proliferate.

Microscopical Examination.—I excised a small piece of tissue from the inner side of the cheek where the pathological condition was well marked and hardened it in absolute alcohol.

The sections were cut in the usual manner and stained in hæmatoxylin, methylene blue, acid fuchsin, and in other ways. They included the epithelial layer and a considerable portion of the tissue beneath. The entire epithelial layer was considerably thickened, being covered by a number of stratified cells containing flattened nuclei and approaching in character the stratum corneum of the epidermis (Fig. 1). The epithelial cell layer below was also found to be thickened, extending in branching processes within the connective tissue below. The lowermost cell layers were normal, readily taking the stain. With this exception, however, all the epithelial cells were the seat of a peculiar change which seemed to be confined almost exclusively to the protoplasm, their nuclei remaining in a normal condition. (Figs. 2 and 3.)

The change or degeneration in question is best seen by an examination of the photographs. (See plate.) The nuclei in some of the cells is surrounded by a clear space due to a retraction of the protoplasm which is broken up into irregular granules and fragments which have a bright glistening appearance, and were not at all stained by the coloring fluids used.

These granules are also seen in the upper stratified layer, but not so clearly as in the cells below.

The granules differed from keratohyalin in their larger size, irregular outline, and in not taking the staining reagents. Their chemical composition and their reaction to osmic acid were not tested.

It is my intention, however, to do so when an opportunity offers of excising tissue from another case.

It is possible that we have to do, as suggested by Dr. Lustgarten, with a cell change allied to that which takes place in the granular layer of the epidermis, leading to an imperfect cornification of the mucous membrane.

It seems more probable that some degenerative change of an unknown nature has taken place in the cell protoplasm, as indicated by the clear space about the nucleus, and by the breaking up of the cell contents into irregular masses.

The mucous glands were normal, their cells presenting no appearance like those in the epithelial covering.

There was also no evidence of an inflammatory process in the subepithelial tissue.

Diagnosis.—In considering the diagnosis of the affection, it could scarcely be confounded with leucokeratosis, which presents a uniform bluish-white discoloration of the mucous membrane and not the pale-yellow color seen in my patient. The granular look of the patches differs from the diffuse change which leucokeratosis presents. In 1890 Unna * described a chronic affection of the mucous membrane of the lips to which his attention was first called by Dr. Baelz, characterized by thickening, suppuration with crusting, and terminating after a variable duration in healing with scar formation.

Unna believed it to be an affection of the mucous glands.

He does not mention any changes in the epithelium that would tend to ally it to the affection under consideration.

Jamieson † has lately discussed some superficial affections of the red portions of the lips, reporting a case which clinically corresponds with Unna's description of Baelz's disease.

Jamieson's case affected a Russian Jew who had been addicted to excessive cigarette smoking. The disease began as a scaling spot which continued for two years, then the lip became swollen to double its normal size. In places it was granular, covered by crusts, and in other parts superficially cicatrized.

A careful microscopic examination was made by a pathologist to whom Dr. Jamieson submitted the specimen. He concluded that in its histological features it approached more the character of a mild superficial epithelioma than any other condition. The labial glands were not found in the specimen examined. Jamieson mentions the close resemblance which his case presented to one reported by Galloway ‡ under the name of Chronic Exfoliating Inflammation affecting the Lower Lip, in which the part was swollen, protruding, and covered by a brownish epithelial crust. The condition had lasted for fifteen years. The patient suffered with dyspepsia and also from seborrhœa of the face and scalp.

Both Jamieson's and Galloway's cases are probably examples of Baelz's disease, although Unna's description had evidently escaped their observation.

* Monatshefte für prak. Dermat., Bd. xi, p. 317.

† British Medical Journal, December 7, 1895.

‡ British Journal of Dermatology, 1895, p. 113.

Volkmann's cheilitis glandularis could hardly come under the list of affections for differential diagnosis, as it was claimed by that author to be an unmistakable affection of the muciparous glands attended by a thickening of the lip. In my case the glands were found to be normal and no inflammation was present.

Although the individual lesions, smaller than a mustard seed, resembled to some extent the milium bodies on the face, they were grouped in patches so close as to be scarcely distinguishable. Independent of a microscopic examination one could not well refer them to the obstructed ducts of the glands, as the lesions were too numerous to be accounted for in this way.

The clinical features of my own case are totally different from any of those referred to, and the histological appearances are so unlike anything that has come under my observation that I report the affection as an example of a mucous-membrane change, which, while apparently not uncommon, has hitherto escaped observation.

A CASE OF SYMMETRICAL MORPHŒA ATTENDED WITH THE FORMATION OF BULLÆ AND EXTENSIVE ULCERATION.*

By PRINCE A. MORROW, M. D.,

Attending Physician to New York Hospital, Skin and Venereal Department; Consulting Dermatologist to St. Vincent's Hospital.

IN the combined returns furnished by the members of this Association for 1894, embracing 24,321 cases of skin diseases, there were 8 cases of morphœa. In a total of 204,866 cases collected to January 1, 1893, there were 78 cases of morphœa. The statistical frequency of this dermatosis as indicated by these returns may be placed at about 1 in 3,000 cases. Scleroderma figures in a slightly larger proportion. From the classification of morphœa and scleroderma under separate headings it might be assumed that they were regarded as distinct diseases. Almost all our modern text-book authorities, with the exception, perhaps, of Kaposi, recognize morphœa as a form of scleroderma, and this view, I take it, is generally held by the members of this Association.

Apart from the comparative rarity of morphœa, certain unusual features presented by a case now under my observation would seem to be of sufficient interest to justify a report of the case to this Association. These features may be briefly summarized as follows: The

* Read at the Twentieth Annual Meeting of the American Dermatological Association, September 8, 1896.

number and size of the plaques, their symmetrical distribution, the occurrence of bullæ, and the extensive breaking down and ulceration of some of the patches. As is well known, the plaques of morphœa almost invariably undergo spontaneous involution. The occurrence of ulceration is an exceedingly rare complication, judging from the few references made to it in the literature of the subject. Sherwell reported a case to the New York Dermatological Society in which a single bulla was observed on a patch of morphœa. A case of symmetrical morphœa somewhat analogous to my own was recently (June 10, 1896) exhibited before the Dermatological Society of London by Dr. Cavafy. There were two small spots of ulceration in a patch over the right popliteal space. The patches were confined to the lower limbs, and much smaller and less numerous than in my own case.

I was first consulted by letter in regard to the case by Dr. A. H. Crane, of Waterbury, Conn., on March 20, 1896, who had been called in as an expert on leprosy, as the physicians in charge suspected this disease. Dr. Crane's large experience with leprosy as resident Government physician on the island of Maui, where I met him in 1889, gave his opinion an especial value. From his description I fully concurred in the exclusion of leprosy, but declined to give a positive diagnosis without a personal examination. The patient was brought to me by his physician, Dr. D. F. Rodger, of Woodbury, Conn., on June 3d, and again in July, when he remained under observation for about two weeks, and again on September 1st. Following is the history of the case as given by the patient, supplemented by Dr. Rodger's notes, which he kindly placed at my disposal:

C. C. P., aged sixty-six years, native of New England, carriage-maker by occupation. Family history as follows: Father died aged forty-five years. Mother at sixty-five years of cancer of the womb. One sister died five years ago of cancer of the breast. Twin sister died suddenly one year ago, cause unknown.

The patient, a well-preserved, healthy-looking man, had always enjoyed excellent health with the exception of an attack of painter's colic when he was twenty-six years old, which compelled him to give up his business of carriage-painter. Ten years later had a severe attack of inflammatory rheumatism, and since then has never been free from rheumatic symptoms, chiefly affecting his shoulders and legs. In August or September of last year he began to experience sensations of stiffness over the surface of the right thigh. He observed that the skin in this region had become changed in color and felt hard, dry, and unyielding, "as if it were about to crack when movement was

made." Shortly afterward similar patches appeared on the right thigh and over the anterior surface of the left thigh, and later below the knees on both legs. In December and January other patches appeared on lower portion of abdomen, about the hips, and back of the shoulders. These white patches looked "as if they had been stamped in the skin"; they were hard and solid to the feel, seeming to justify the patient's expression to his family, "I believe I am going to ossify." He came under Dr. Rodger's care January 16th, and I quote from his notes as follows: "The plaques continued to increase in size, and other plaques appeared principally upon the anterior surfaces of both thighs and lower portion of the limbs. These plaques include within their borders from thirty to sixty square inches, resembling large areas of skin under which slices of fat pork had been inserted, losing somewhat their lardaceous appearance toward the edges, each being surrounded by a narrow lilac-hued border separating the healthy skin from the affected portion.

"Some time in December there had been a breaking down of the tissues included in the outlined areas over the entire tibial region. The ulcerative process was peculiar; it did not occur in the entirety of the affected area at once. A ridge might develop like a cord from one to several inches long, and from this in all directions the skin would rise up like coarse lymph granulations, or these large lymph granulations might be the first indication of the beginning of the destructive process. These, filling with an amber fluid, would open, when an ulcerative process was found to exist at the bottom. This would continue until the ulcerative and breaking-down process would come to the lilac border, never proceeding beyond this line. The process of repair would proceed from the center of the affected area toward the circumference following the wake of the destructive process. These broken-down areas were very sensitive; the pain was of the lancinating type. As the patient expressed it, 'the sensation was as if millions of needles were being thrust in.'"

Dr. Crane's description of the ulcerative process is as follows: "The breaking down of the indurated tissues in the leg is first in the form of a gelatinous softening, followed by ulceration." There has been no pain except in the ulcerated patches below the knees. The only subjective sensation that the patient has complained of has been an extraordinary sensitiveness to cold; when sitting in a warm room, the opening of an outer door would cause a sensation of chilliness to pass through him. He found it impossible to keep his lower limbs warm. Even after the summer set in, with the thermometer at 90°,



Fig. 1.

the only way he found to keep comfortable was to sit in the sun with his leg wrapped up in a buffalo robe.

Status Præsens.—The several photographs I now exhibit, taken June 3d, give a fair idea of the localization, extent, and general aspect of the disease. The front view (Fig. 1) shows a large irregular plaque extending from the right groin to just above the knee, almost completely covering the anterior and outer surface of the thigh, sweeping over its inner aspect and lost to view over the outer lateral and posterior surface. In Figs. 2 and 3 these prolongations are seen on the outer aspect and back of the limb, entirely investing the thigh in its middle and lower third. This large irregular plaque is seen to be made of a series of smaller plaques which have become confluent, their lines of coalescence being readily distinguishable.

Above Poupart's ligament is seen a broad bandlike plaque, several inches in width, extending from the pubes obliquely upward and outward over the right abdomen, emerging upon the back of the trunk at a point midway between the axilla and the left anterior superior spine of the ilium. Below this is seen a narrow band made up of streaklike patches extending transversely across this region. On the left abdomen are seen two broad white bands, the lower extending from the pubes transversely across over the left anterior superior spine, the other somewhat crescentic in shape, sweeping upward and outward until it is lost on the back.

Over the anterior surface of the left thigh are seen a number of plaques, for the most part discrete; on the outer aspect of the thigh they have become confluent at certain points, but do not form a continuous sheet as over the right thigh; this is doubtless due to their less advanced development. Fig. 2 shows the backward prolongation on the limbs and trunk of the plaques seen in Fig. 1; also a small patch on the right side just below the axilla, and the faint outline of patches on the back and between the shoulders. These latter are better shown in Fig. 3, as are also the patches on the posterior aspect of the limbs. Over the right scapula is seen a large, irregularly shaped patch, a smaller one over the left scapula, while between them, extending down the middle of the back for several inches, is a large patch of considerable dimensions; on the inner side of the buttocks, partly hidden by the folds of the nates, is a palm-sized patch.

In shape the plaques exhibit the most diverse contours, irregularly circular, oval, oblong, crescentic, etc. They are sharply defined, slightly elevated, each surrounded by a delicate though quite distinct erythematous border. Some of the patches present a white raised



Fig. 2.

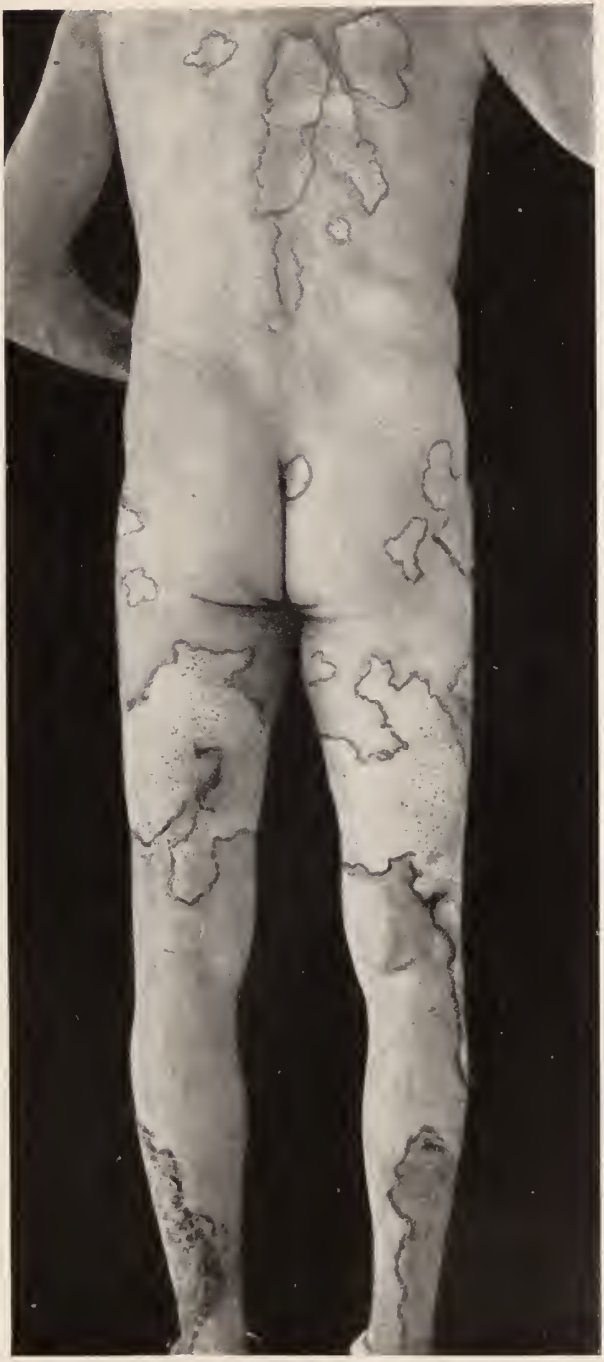


Fig. 3.

œdematous appearance as if a hot iron had been pressed upon the skin. The oldest large patch on the right thigh has a dirty-white hue, like snow sprinkled with soot. The white central areas are stippled over with numerous punctiform indentations, corresponding doubtless to the follicles of the skin.

The affected surfaces are absolutely denuded of hair. There is also complete suppression of the sudoral and sebaceous secretions. To the feel the skin is rigid and unyielding and can not be pinched up. The surface of the right thigh is of a boardlike hardness.

Perhaps the most interesting feature of the case is the ulcerative process which involved almost the entire surface of the legs from the knees to the ankles. At one point on the outer aspect of the right leg it had extended several inches above the knee and backward into and above the popliteal space. The entire area involved in this process is not shown, as partial cicatrization had already occurred when the pictures were taken. Upon his second visit in July the ulcerated surfaces had entirely healed, leaving what might be termed hypertrophic cicatrices, the hypertrophy being much more marked at the borders of the patches, forming ridgy elevations several millimetres above the niveau.

Upon the cicatrized surfaces were observed numerous small exulcerations from the breaking down of bullæ, which would form here and there from day to day. Sometimes half a dozen would form in a single day. These bullæ were about the size of a marrowfat pea or larger, of a pearly color, with a thicker epidermal covering than the ordinary blebs of pemphigus and tensely distended with a clear, slightly gelatinous fluid. When ruptured spontaneously or artificially broken they would leave an excoriated surface which would heal over in a few days. This process was going on all the time the patient was under my observation in July, and continued when he was last seen, September 1st.

During this period I had an opportunity of observing the mode of formation of the white plaques. When the patient came, I asked him to point out to me the most recent sign of the disease. He indicated an erythematous patch on the outer aspect of the left thigh. Within a few days the center appeared slightly elevated, and as if sown with numerous white dots or streaks, which gradually coalesced, forming a white macule about the size of a silver half dollar.

In the interval between his first two visits many of the patches had grown perceptibly larger. It was to be noted that as the white central area increased in size the erythematous margin enlarged *pari*

passu. In some cases there was a serpiginous spreading of the patches, in others the patch would advance by throwing out tonguelike prolongations or spurs as in keloid. By whatever mode of extension, the pigmented zone would precede the advance, and was always *en évidence*.

As a feature of minor interest may be mentioned the disturbance in the nervous and vascular apparatus of the affected areas. Sensation to pain seemed to be little if any impaired. In getting specimens * for microscopical examination I selected a patch of recent development, and the section embraced a portion of the white patch and its violet border. It was curious to note the varying degrees of rapidity with which these different zones reacted to the chloride of ethyl. The outlying sound skin was frozen in a fraction of a minute; it required a longer time to freeze the lilac border, while it required two or three minutes to freeze the central white zone.

Another feature of interest was the compensatory hyperidrosis over the sound skin; according to the patient, he did not sweat at all during the winter, but when I saw him in the summer the sweat seemed to run down in rivulets from his face, head, and upper portions of the body, while there was a comparative absence of perspiration from his waist downward.

On the patient's third visit (September 1st) a marked improvement was manifest. Many of the patches had begun to disappear and no new ones were forming. In the retrograde metamorphosis the white surfaces are gradually effaced, leaving slightly pigmented areas. The ridgy elevations of the cicatrices were less pronounced. The surface was covered by a pinkish epidermis more or less scaly and exfoliative. The bullæ continued to form, but were not nearly so numerous.

The treatment may be briefly indicated. The patient was first ordered thyroid extract, five grs. three times daily, gradually increased to twenty-five grs. per diem, and large doses of iodide of potassium, with a simple protective dressing for the ulcerated surfaces.

Upon his second visit Merck's thyroidin was substituted for the thyroid extract, and salicylate of sodium for the iodide of potassium. Under this treatment improvement has steadily progressed.

* These specimens were submitted to Dr. A. R. Robinson for examination. His report will appear in a subsequent number of this journal.

A CASE OF PAGET'S DISEASE OF THE NIPPLE.*

BY GEORGE THOMAS JACKSON, M. D., New York,
Professor of Dermatology in the Woman's Medical College of the New York Infirmary; and in the Medical Department of the University of Vermont.

THE unreliability of statistics is well shown by a glance at the statistical returns of the American Dermatological Association. In the combined returns from 1877 to 1893 no mention of Paget's disease is made either under the commonly used title I have chosen for this paper, or under any other name suggested for it. These statistics cover 204,866 cases. Doubtless some cases are hidden from sight, or, better, buried forever under the title of epithelioma or carcinoma. In 1894, among 24,321 cases we find one case of the disease reported from New York. So far as I know there are no statistics so complete as ours are, yet how shall we regard the disease as to frequency of occurrence? Our statistics would say once in 229,187 cases, but not one of us would accept that as true. At any rate it is a rare disease. It so happened that in the autumn of 1895 I saw two cases of Paget's disease, one in my service at the Woman's Medical College of the New York Infirmary, and one in the practice of Dr. B. Farquhar Curtis, of New York, who kindly sent the patient to me for confirmation of his diagnosis and opinion as to the advisability of operation.

I would briefly report my own case. I would say that it was seen by Dr. George H. Fox and by Dr. B. Farquhar Curtis. The latter operated upon it, and by both of these gentlemen the diagnosis was confirmed.

Matilda K., aged fifty-two years, born in Germany; married. The family history is unimportant. The patient gives a history of having had rheumatic fever when she was sixteen and when she was twenty years of age. She was married when she was forty years old, and had two children. The youngest child was born ten years before the trouble with the breast. She suckled both her children, the last one for eighteen months. She never had any disease of the breast during lactation. She has always menstruated regularly, and does so still. She enjoyed good health up to December, 1894, when she had a slight stroke of apoplexy followed by paralysis, that in course of time lessened. The patient came to the dispensary in the fall of 1894

* Read at the Twentieth Annual Meeting of the American Dermatological Association, September 8, 1896.

for an inflammation about the right nipple. I did not see her then. Apparently it was taken for a simple inflammation and treated with simple remedies. These seem to have relieved her for a time.

I saw her for the first time in May, 1895. At that time she presented herself on account of a return of the inflammation of the nipple. She said that the first thing she noticed was that there was itching about the nipple, and that the areola became red and looked angry. When I saw her in May the appearances were those of a chronic eczema, some crusting, and an eroded surface. There was then no pain complained of. On account of the markedly circumscribed character of the patch, its limitation to the nipple and areola, and the slight amount of induration of the lesion, together with some hardness of the breast, I made a tentative diagnosis of Paget's disease, and directed that she be kept under observation and the lesion treated as an eczema.

About the middle of September, 1895, she came again to my clinic. Since last seeing her a marked change had taken place. The nipple had become very much depressed. The whole areola was very much indurated. The site of the nipple and areola was occupied by an eroded, red, irregular-shaped patch. It was perfectly dry and looked raw. Outside of this there was a narrow line of apparently normal skin, and outside of all, extending nearly around the whole diseased patch, there was a light brown, infiltrated, slightly elevated ridge. There were no dilated blood-vessels. The patient complained of a good deal of itching and of sharp, sticking pains in the breast. The breast felt hard, and the axillary glands of both sides were enlarged. There now being no doubt of the nature of the trouble, amputation was advised.

On October 16, 1895, Professor B. Farquhar Curtis amputated the diseased breast in the New York Infirmary, and removed the enlarged glands from the right axilla. The patient made a good recovery, and was discharged from the Infirmary on October 30, 1895.

I saw the patient again on June 17, 1896. The scar from the operation was perfect. There was no sign of a return of the disease. There were no enlarged glands in the right axilla. The patient stated that she had been entirely free from pain since the operation. She had a second attack of paralysis in December, 1895. In the left breast there was a hard, circumscribed, nodular mass. She said that she had had this lump in the breast for years, and that it gave her no pain.

We have here an instance of the development of what seemed to

be a simple eczema into a well-marked case of Paget's disease within about ten or eleven months. The clinical diagnosis was confirmed by the microscope. The pathological examination was made for me by my friend Dr. John Slade Ely, Professor of Histology and Pathological Anatomy in the Woman's Medical College of the New York Infirmary, and Assistant in Pathology in the Medical Department of Columbia University. His report upon the findings in the case is as follows:

Professor John Slade Ely's Report.

The specimen is a breast which has been removed by operation and comprises the entire mammary gland, a considerable piece of the skin covering it, and surrounding fat and pectoral muscle.

The skin appears normal except where it covers the nipple and its areola, where it is somewhat coarsely seamed and appears to be thickened. Surrounding the areola there is a circumvallate depression, in places as much as two millimetres and a half in depth, which separates the thickened tissue of the areola from the normal surrounding skin. Just within this depression there is a zone of hyperæmia about two millimetres in breadth. Though coarsely seamed, as above mentioned, the skin covering the nipple and areola is in general smooth, showing neither ulceration nor crust formation. The nipple is not sunken or noticeably retracted, though it projects very little above the level of the surrounding skin.

Median section through the nipple, its areola, and the entire breast shows the skin covering the nipple and areola to be distinctly thickened and the site of the mammary gland to be occupied by a large, dense tumor. This tumor measures $8.1 \times 7.6 \times 4.7$ centimetres. It is quite sharply circumscribed, though not distinctly encapsulated, and, except where it is connected with the nipple by the lactiferous canals and their supporting connective tissue, it is completely surrounded by fat. The substance composing the tumor is extremely dense, resembling in appearance the tissue of dense fibroma. It shows no distinct lobulation, but is somewhat mottled in places, as the result, apparently, of the presence of small, more or less circular areas of somewhat less dense tissue of a slightly yellowish color. A few small cysts are evident, the largest not more than three millimetres in diameter, and containing clear or only slightly cloudy liquid material. The blood supply of the tumor appears to be meager.

The fat tissue surrounding the tumor appears normal, as does also the portion of pectoral muscle attached to the specimen.

Microscopic examination confirms the impressions obtained from gross inspection of the specimen.

The skin covering the nipple and areola is much thickened. This is chiefly the result of a very considerable development of connective tissue in the corium and of an inflammatory infiltration of its papillary layer, though the epidermis is also thicker than normal. These changes are evident everywhere in the skin covering the nipple and areola, but are more intense in that of the areola, and the details of the changes about to be described are those which have been observed in that region more particularly.

The corium here is upward of four millimetres in thickness. Its deeper layer consists of bundles of dense connective tissue surrounding masses of unstriped muscle. It is poorly supplied with blood-vessels, but where these are visible they are often surrounded by collections of cells, for the most part of the small spheroidal type and mononuclear. This cellular infiltration about the blood-vessels increases toward the more superficial layers of the corium, becoming very intense in the papillary portion, where it is not limited to the immediate proximity of the blood-vessels, but is quite general throughout the tissue. The cells here are also in great part of the small spheroidal variety and mononuclear, but there are also many larger spheroidal, polyhedral, and spindle cells. These cells all lie in a reticulum of fibrous connective tissue which is finer in the more superficial parts, coarser below. The cells and fibrous reticulum of the papillary layer are often not in close juxtaposition, but are separated by clear spaces such as are observed in tissues which have been the seat of œdema. This change is very marked. In the papillary layer, also, are many thin-walled blood-vessels, whose endothelium is swollen and whose lumina contain variable numbers of polynuclear leucocytes. The majority of these blood-vessels would appear to have been considerably congested. A few polynuclear leucocytes are also observed in the tissue outside the blood-vessels.

The changes in the epidermis are even more pronounced than those in the corium. All the layers of the epidermis are thickened. In the rete Malpighii the cells of the deepest layer appear to have undergone a more rapid multiplication than normal, being very closely packed together and rather small. More superficially the cells are seen to be passing through the various transitions characteristic of the rete mucosum, but in the majority more or less abnormity is discernible. This appears to be due in most instances to swelling of the cell bodies, which are more spheroidal than normal and consist

of rather coarsely granular protoplasm. Many of the cells also inclose clear, more or less globular spaces, now apparently empty. These spaces often occupy the greater part of the cell body, leaving only the nucleus intact, but usually a small amount of finely granular protoplasm surrounds the space, or is visible at one side of the cell surrounding the nucleus. At times these spaces appear to surround the nucleus in a ring, giving it a vacuolated appearance, and under these circumstances there is usually visible a distinct zone of protoplasm about the vacuoli. The outlines of these peculiar cells are, as a rule, very distinct, though they can not be said to have a definite wall. In many instances the cells immediately adjacent to these swollen cells appear to have been compressed by their enlarged neighbors, at times presenting in section a distinctly crescentic appearance, the vacuolated cell occupying the concavity. The nuclei of the cells are for the most part well preserved, though occasionally somewhat distorted in the vacuolated cells; their chromatin stains well with the ordinary nuclear dyes.

In addition to the changes in shape and appearance of the cells of the rete Malpighii, there is also noticeable an increase in the intercellular spaces, which are distinctly broader than usual. This is particularly evident in the region of the spine cells, where the channels separating the adjacent cells are very wide. These intercellular spaces now appear to be empty.

The changes above described are everywhere evident, but are so intense in places as to completely destroy the regular stratification of the rete Malpighii and to give it the appearance of a confused mass of swollen epithelial cells loosely and indiscriminately thrown together.

The stratum granulosum of the epidermis is much thickened where the changes in the rete are pronounced, and the cells composing it are very granular and are larger than usual. The stratum lucidum is also much increased in thickness in places, apparently as the result of excessive swelling of its component cells, which are often almost spherical in shape. These swollen cells of the stratum lucidum show little besides the cell outline and a small faint nucleus, the entire cell body having been occupied by some substance which has disappeared in the process of preparation of the specimen, the space formerly occupied by it showing now only as a hollow cavity. The same separation of the cells noticed in the rete Malpighii is also observable here.

The stratum corneum is also greatly thickened. In its deeper layers the cells are much swollen, presenting a similar appearance

to those of the stratum lucidum, and throughout its entire thickness the intercellular spaces are markedly increased, forming irregular cavities, often of considerable size, now destitute of contents.

The changes in the skin above described are sharply limited by the circumvallate depression surrounding the areola, the skin beyond this point showing no pathological change other than a moderate infiltration of the perivascular spaces of the corium by small spheroidal cells, even this slight change quickly disappearing as the distance from the areola is increased.

The lactiferous canals in the nipple and just beneath it are irregularly dilated, and are everywhere filled with desquamated, swollen, and degenerated epithelium and polynuclear leucocytes. In many of the epithelial cells distinct vacuoles are visible similar to those observed in the cells of the rete Malpighii, though this change is never so intense as in the skin. The connective tissue surrounding the lactiferous canals is moderately infiltrated with small spheroidal cells. No marked congestion of the blood-vessels about these canals is observed.

The tumor, occupying the mammary gland, is composed for the most part of extremely dense, white fibrous tissue disposed in bundles of various sizes, often distinctly wavy and quite lawless in arrangement, many of which show evidence of hyaline degeneration. This connective tissue occupies the spaces between the lobules of the gland, separating them widely from one another, and penetrates the individual lobules. Immediately about the acini of the lobules it is less dense and appears younger, connective-tissue cells being relatively more abundant. The network of fibers is here also very much more open than in the interlobular regions, disclosing many open spaces between the fibrils and presenting the apppearance often met with in œdematous tissues. The acini inclosed by this tissue are often widely separated by it, and show more or less abnormity of size and shape. Some degeneration of their lining epithelium is also noticeable, but this is far less striking than in the epithelium of the lactiferous ducts. Though in some instances the acini of the lobules branch somewhat irregularly, the impression conveyed is rather that of inflammatory hyperplasia than of adenoma.

In places in the dense fibrous tissue of the tumor there are collections of small spheroidal cells, mononuclear, and resembling very young connective-tissue cells. These are interpreted as marking the site of active development of the connective tissue at the time of removal of the mass.

Near the center of the tumor there are a number of small cysts, lined with cuboidal or irregular epithelium, and containing loose granular material and desquamated cells. A few of these cysts are regular in outline, but the majority of them are irregular, showing what appear to be papillary ingrowths of connective tissue into their lumina. These ingrowths consist of connective tissue of the same characters as that found about the acini of the lobules, and are covered with epithelium similar to that lining the rest of the cyst wall. The picture in these cases is very suggestive of that presented by the papillary ingrowths observed in the early stages of intracanalicular fibroma of the breast and in papillary cyst-adenomata of the ovary.

Though numerous specimens have been stained for bacteria and for parasites of the sporozoa type, none have been found.

The changes above described are substantially those which have existed in all the cases of Paget's disease which have been subjected to careful pathological study.

Consideration of the significance of these changes leads to the conclusion that the lesion in the skin is essentially of an inflammatory nature. And they furthermore suggest that the inflammation which gave rise to them was of slow progress, was primarily and pre-eminently a change of the corium, and was of such a nature as to cause a very considerable connective-tissue development, and, by interference with the nutrition of the skin, to lead to an intensely œdematous condition of the epidermis and of the papillary layer of the corium.

The tumor of the mammary gland may be regarded as fibroma durum or as the result of long-continued interstitial mastitis, the lines separating these two conditions being at the present time exceedingly vague. For my part, I would prefer to consider the present growth as fibroma of the so-called "pericanalicular" variety, basing this opinion chiefly on the lawlessness of the fibers composing it. It is certainly neither adenoma nor carcinoma.

That the two conditions here met with should be associated appears most natural when we remember the close similarity in the lesions (both consisting chiefly of connective-tissue development) and the intimate topographical and genetic relationship of the skin of the nipple and areola with the glandular element of the breast. The determination of the precise chronological sequence of the two conditions, however, presents some difficulty. In a large majority of the cases of Paget's disease thus far studied, the attention of the patient has been attracted first to the lesion of the skin, and the mammary tumor has remained undetected until it has attained to a very

considerable size or has been noticed by the physician in his examination. This has led to a widespread belief, expressed also by Paget in his first description of the condition, that the change in the skin antedates the lesion of the gland and is in some remote way its cause. In the present case I am loath to regard the lesion in the skin as primary, basing this opinion on the large size of the tumor, on the extreme density of the tissue composing it suggesting its long duration, on the nature and relatively slight intensity of the skin lesion, on the frequency of occurrence of fibrous growths in the breast independently of any pre-existing skin lesion, and on the absence of any evident ætiological factor in connection with the skin lesion other than the large fibrous tumor closely underlying it.

In the description of the changes in the epidermis and in the lactiferous ducts mention has been made of certain spheroidal, clear spaces or vacuoles commonly met with in the epithelial cells. These have been described by Darier, Wickham, and others as psorospermæ, and have been regarded by them as the primary ætiological factor in the induction of the disease. A careful study of these "bodies" in the present case has produced a strong belief that they are in reality not psorospermæ but spaces in the cells, and they have accordingly been described as such, spaces which have formed as the result of an accumulation of clear liquid within the cell bodies, such as is seen in extreme dropsy of cells or in hydropic degeneration, as it is characterized by Ziegler. This change is relatively frequent in the inflamed skin covering superficial tumors—I have met with it in much greater intensity than in the present case in the epidermis covering a melano-sarcoma of the heel—and I have seen nothing in the present case which is not abundantly explained on the supposition that the condition is here one of extreme inflammatory œdema of the cells. And in this connection it may be stated that I have seen appearances apparently identical with all those pictured by Wickham in his elaborate study and interpreted by him as indicative of the presence of psorospermæ. And, finally, the sharp limitation of the supposed psorospermæ to the epithelium seems to be inconsistent with any conception of them as parasites responsible for the genesis of a distant neoplasm in which they are not found.

In conclusion, then, I find it much more consistent to consider the lesion of the skin as a secondary inflammatory process resulting in some way from the large underlying tumor of the mammary gland, and to admit that in the present state of our knowledge the precise exciting cause of the tumor and the exact manner in which its pres-

ence induces the inflammation of the skin must be regarded as uncertain.

After seeing my patient in June of this year (1896) I wrote to Dr. Ely, telling him that I found a tumor in the other breast. Replying to my letter, he said: "Its contents is an extremely interesting corroboration clinically of the findings of the report, both as to the nature of the tumor and as to the priority in time of the tumor to the skin lesion. Such fibrous growths as the tumor in the present case are very apt indeed to affect both breasts, while adenoma, carcinoma, etc., very rarely affect both. I think that you may be sure that the mass in the other breast is not carcinoma, but fibroma or interstitial mastitis."

It would a waste of time for me to dilate upon the symptoms of Paget's disease of the nipple before such an audience. Dr. Ely has begun a critical study of its pathology which he hopes to publish in a short time. In writing this paper I had two objects in view—namely, to put on record another case of this rare disease, as it seems to me to be the duty of every one to report every case of a rare disease, and to elicit from you a discussion upon its treatment, as it is to such bodies as we are that the profession looks for guidance in the treatment of rare diseases.

In looking over Wickham's admirable treatise upon Paget's disease * you will find a record of some eighteen cases. Paget reported fifteen cases not abstracted by Wickham. Besides these, Elliot reported one case; † Jamieson reported in his Treatise on Skin Diseases two cases; ‡ Audry, one case; # Fleming, one case; || Anderson, one case; ^ Lewis, one case; ◊ and Duhring, three cases. I do not offer this as a complete list of the cases reported, but they are unselected and enough for my present purpose. With the case now reported we have forty-five cases. Of these it is said that in twenty-four cases carcinoma developed in the breast which was the site of Paget's disease; in four of them the breast is said to have felt hard; and in one of them, my case, a fibroma was found as the cause of the hardness of the

* Maladie de la peau dite maladie de Paget, Paris, 1890.

† Journal of Genito-Urinary and Skin Diseases, 1892, vol. x, p. 272.

‡ Annal. de dermat. et syph., 1896, t. vii, p. 644.

British Medical Journal, 1891, vol. i, p. 846.

|| Glasgow Medical Journal, 1892, vol. xxxvii, p. 138.

^ Glasgow Medical Journal, 1892, vol. xxxviii, p. 132.

◊ Medical Record, 1887, vol. xxxi, p. 641.

breast. That is, in twenty-nine out of the forty-five cases there was some disease of the gland in connection with the disease of the nipple. Only one of the forty-five cases is reported as cured by treatment addressed to the skin. The history of the vast majority of them is that they grew steadily worse under treatment, no matter whether mild or most energetic with powerful caustics or the curette. On the other hand, in the cases operated on most did well, though in three of them a general carcinosis developed, and in one death resulted from a secondary deposit in the brain.

We learn from this that the tendency of the disease is to the development of carcinoma. Moreover, we find that it is eminently refractory to treatment addressed to the skin lesion. It is possible, as the histories show, to produce an amelioration. It is doubtful if a lasting cure can be obtained after the disease has plainly declared itself. We also find that we have reason to expect good results from amputation of the breast.

When we consider the malignant tendency of the disease and its obstinacy to treatment, it seems to me that it is our duty in all cases to advise amputation of the breast just as soon as we are sure of our diagnosis. Of course, as long as there is any possibility of the trouble being a chronic eczema or a dermatitis of simple character, operative interference is not to be thought of. Usually it will not take one who is at all expert in dermatology very long to assure himself, one way or the other, of the nature of the case. As most of the women are past the childbearing age, and the breast is useless so far as any function of the organ is concerned, and as the mortality of breast amputations is very slight (Dr. B. Farquhar Curtis informs me that it is from one to four per cent), we can advise operation as a preventive of future trouble with good grace. Of course, when there are signs of involvement of the breast, no one would hesitate to insist upon amputation of the gland. It is true that in my case my pathologist reports that the tumor of the breast was not malignant. But the clinical signs of carcinoma were present, and it would have been impossible, probably, to determine the nature of the tumor without amputation. I feel that I was justified in advising amputation even in this case, and in the absence of malignancy of the tumor, as the patient, by the comparatively trivial operation, was promptly cured of an otherwise practicably incurable disease, and at once freed from all pain and annoyance.

Society Transactions.

AMERICAN DERMATOLOGICAL ASSOCIATION.

TWENTIETH ANNUAL MEETING, HELD AT HOT SPRINGS, VIRGINIA, SEPTEMBER 8, 9, AND 10, 1896.

A. R. ROBINSON, M. D., of New York, *President.*

President's Address.—DR. A. R. ROBINSON, of New York, delivered an address of welcome in which he spoke in high terms of the character and ability of the late Dr. Edward Wigglesworth, of Boston, and the loss the association had sustained by his death. The field which the dermatologist cultivates the speaker looked upon as a most important and extensive one, and still the specialist in this branch does not yet hold the position he should in the eyes of the general profession. One reason for this is the attitude of most medical schools in this country in not looking upon the study of cutaneous diseases as a natural and necessary part of the college curriculum. Medical education, he said, has not yet reached a common-sense basis. The school has no right to pronounce a man capable of treating diseases of which it has given him no knowledge. Classes are habitually too large for proper clinical instruction. The physician graduated without the ability to diagnosticate and properly treat diseases of the skin is not justified in accepting a fee from a patient with a disease of this nature, if a properly qualified physician is within reach. The English custom of granting one degree for graduates in medicine and another for graduates in surgery, if adopted here would, the speaker held, be a step in the right direction. Attention was called to the many unnecessary operations which result from the family physician calling in a surgeon instead of a dermatologist in doubtful cases, in which the diagnosis lies between sarcoma, lupus, tuberculosis, and syphilis. Instances were quoted to show how slight and often overlooked eruptions pointed to the true condition, and would, if recognized, save the patient from the knife. To obtain proper recognition by the schools, the general practitioners, and hospital authorities, so that teaching and practicing in public as well as private may become what they should be, the dermatologist ought to be more aggressive toward notorious offenders, and show by his works the great importance of this special branch to humanity. Papers representing original research should be published only in journals devoted

to the special branch, so that the dermatologist could keep track of the subjects; while those intended to instruct the general practitioner or to acquaint him with the fact that the writer is devoting his time to dermatology can be printed in journals devoted to general medicine. The speaker opposed strongly the reading or publication of papers the sole purpose of which was to advertise the writer. Admission to the association should be a goal for every true worker in dermatology, to be gained by hard labor. One who writes for notoriety is not likely to bring much credit upon the association, one of whose objects is to guard the dignity of dermatology.

Dr. James C. White, of Boston, said he had listened to the address with great pleasure. Regarding the matter of securing proper education in dermatology in the medical schools, he would say that for several years Harvard University has required examinations in dermatology. Now, a student must have in his third year a considerable knowledge of dermatology, both theoretical and practical. The examination is a very rigorous one, and may exclude from the degree. Such an instance occurred only this year. In the fourth year, dermatology is an elective study.

Another point in the address which had seemed to him important was that regarding the devotion of more time at the meetings to the exhibition of specimens, photographs, and patients. At the recent International Congress of Dermatology in London there was the usual set programme, the papers were prepared beforehand, and the old and well-known views of the writers were presented, allowing but little time for discussion. In this way, the members went away with their opinions but little changed by the meeting. In the London congress, however, there had been also a new and admirable feature—viz., a long session in the morning, and another in the afternoon, devoted to the exhibition of patients. These patients were inspected by the members, and informal discussions held with regard to them. A most extraordinary collection of cases had been shown, and he felt sure that every one must have gone away with the feeling that there were certain fields of dermatology about which he knew but little. This was certainly a great object lesson in dermatology. Such a feature could not be introduced in the meetings of this association if they were held at long distances from cities. Another feature at the congress was the exhibition of photographs and models of both the rare and the more common diseases. There were many microscopical specimens exhibited under hundreds of microscopes. Bacteriological culture specimens and drawings were shown also in large numbers. These features certainly gave to the congress a most distinctive character, and one which he hoped would serve as a model for the future meetings of this association.

Dr. L. A. Duhring said that in the president's admirable address reference had been made to the instruction given in dermatology in the universities and colleges of this country. It had occurred to him while

listening to these remarks that some notice should be taken of the good work that had been already accomplished in that direction by a few universities. As had been remarked by Dr. White, Harvard University had for several years past required the students before taking their degree in medicine to pass an examination in diseases of the skin, just as they did in the other well-recognized branches of medicine. All would agree that this was a step in the right direction, and all would hope that the time was not far distant when such a rule would be adopted by every other college in the country. The speaker said that he had found that the profession at large had been distinctly averse to instituting a reform of this kind. This arose from ignorance, which he hoped would soon be overcome. The professors in the other departments have not regarded the subject of cutaneous medicine as one of importance, and it was only with great difficulty and hard work upon the part of teachers that these innovations were accomplished. The faculty of the University of Pennsylvania had lately ruled that the student should appear for an examination in dermatology for his degree of M. D. Reforms of this kind, made from time to time in other universities, would soon lead to the adoption of this course by all the medical schools.

DR. GEORGE T. JACKSON, of New York, said that he would like to place on record the fact that for several years past the students in the medical department of Columbia College had been required to pass an examination in diseases of the skin. After this year they would be required to take a course of twelve lessons on diseases of the skin, and, besides attending the regular weekly clinical lecture, to be examined in this branch.

DR. P. A. MORROW, of New York, said that he was much interested in this matter of dermatological instruction in colleges, and that this had been the topic of his presidential address before this association six years ago. He referred to it now only to show the very desirable advance that had been made in this direction. He had at that time sent a note of inquiry to every medical college in this country. At no college at that time was instruction in dermatology imperative or compulsory—in other words, it did not form a necessary element in the course of instruction. He had referred in that address to the fact that in Harvard and in Columbia College a knowledge of certain branches, among others dermatology, was elective. It was, therefore, a source of much satisfaction to learn from the previous speakers the fact that a knowledge of dermatology was now required by three of the leading universities in this country, and that it formed a necessary and integral part of the curriculum in these institutions.

DR. ROBINSON said, in closing, that he was aware of the instruction in Harvard and the University of Pennsylvania, and, he thought, also in Columbia. He was free to admit that there had been an advance in

this direction, but his argument was that if we asserted the dignity and value of our specialty more, the advance would be more rapid. As regards teaching, he would still hold that where there was a large number of students, as in the College of Physicians and Surgeons, it was an utter impossibility to teach dermatology properly. At the New York Polyclinic he could not teach more than thirty-five or forty students at a time, even though the clinical material was abundant. He had, therefore, said that those showing a special knowledge of the subject should be given a special certificate. By a limitation of the number of subjects to be studied in each department, a proper time could be given to the study of dermatology.

Notes on Dermatitis Venenata.—By Dr. James C. White, of Boston.

Dr. White presented a brief description of the action of certain substances upon the skin which were not contained in his work on dermatitis venenata published in 1887, and gave statistics illustrating the frequency of this affection.

The substances were as follows: *Pastinaca saliva* (common parsnip), *Hamamelis Virginica* (witch-hazel), Oleum cassiæ, *Ostrya Virginica* (hop hornbeam), and shirts dyed with an aniline black.

Dr. Duhring said that now, as on previous occasions in listening to the observations of Dr. White and in reading his papers, he had been struck by his large experience with dermatitis as the effect of poisonous plants, an experience which had been very different from his own. It was true that their fields of observation were several hundred miles apart, which might partially explain this difference, but he felt sure that these affections of the skin must be much more common in New England than in the vicinity of Philadelphia. It should be remembered, of course, that Dr. White had an unusually large dermatological clinic, yet in his own experience of twenty-five years he had not met with anything like the same number of such cases. He could not at the moment give the exact figures, but these cases were certainly much less frequent in the vicinity of Philadelphia. Although long connected with several dermatological clinics, cases of inflammation of the skin from poisonous plants were uncommon, and this was true even of rhus poisoning. The plant was certainly sufficiently common, but the persons poisoned by it were not at all numerous, according to the statistics of the clinics. The points brought forward in the paper constituted a valuable contribution to the history of this subject.

Dr. John T. Bowen, of Boston, said that he had had an opportunity of seeing several of Dr. White's cases of poisoning from black shirts. Some of these had simulated very closely the dermatitis produced by copaiba. They presented the peculiarly bright red color, and the dermatitis was especially located over the joints.

Regarding the matter of poisoning from black stockings, he would say that he had not found dermatitis from the wearing of black stock-

ings so uncommon as Dr. White had intimated. In two or three instances the stockings had been examined with negative result.

DR. J. A. FORDYCE, of New York, said that among the cases of inflammation of the skin from external causes which he now recalled, was one produced by a very small amount of resorcin, given for an eruption of the skin closely allied to eczema seborrhoicum. A salve containing twenty grains to the ounce had been prescribed, and had produced a violent inflammation; even an ointment containing only five grains to the ounce produced a very serious reaction. The internal use of resorcin in this patient also produced an eruption on the skin, showing a peculiar idiosyncrasy to the drug on the part of the individual. In another case, seen some time ago, an eczematous and papular eruption, the latter situated about the hair follicles particularly, was found to be due to the irritation of paraffin oil. The eruption was situated on the hands and forearms, and extended almost to the shoulder.

DR. MORROW said that Dr. White's contribution possessed a special value, for he was not aware of any other observations of a similar nature, particularly regarding some of the agents mentioned. He thought if we carefully studied the ætiology of the various forms of dermatitis, we should find that external irritants played a much more important part than was generally supposed. It had been his custom for a long time past, on seeing a case of dermatitis on the exposed parts, differing from an ordinary eczema, to inquire into the occupation of the patient. Such careful inquiry had surprised him by the number of cases in which he had been able to trace external irritants as an ætiological factor.

He recalled two very persistent and obstinate instances of dermatitis which did not yield to ordinary treatment. The eruption was confined to the hands, forearm, face, and neck. The first patient was a worker in ivory and was exposed to contact with very minute particles of ivory which were thrown off in the process of grinding down and polishing the ivory. The patient was asked if he knew of other workmen similarly affected. He replied that there was one other, and on examination this second person was found to be suffering from a similar eruption. These cases of dermatitis were improved somewhat by the use of protectives, but, as neither of the patients was willing to change his occupation, they were not cured.

Dr. Morrow said that he thought we should find that the ætiology of many of these affections was quite complex. They were usually explained on the assumption of a special idiosyncrasy, but there were doubtless other contributory causes. In the cases referred to in the paper under discussion, it seemed as if the irritant had to be applied for a considerable time in order to produce the effect, and in addition there was also a certain condition of the atmosphere—e. g., a long heated term. It was evident, therefore, that something more than idiosyncrasy was requisite.

Dr. C. W. Allen said that he had been much interested in the paper, and also in the remarks of Dr. Duhring regarding the geography of these affections. The statistical returns of this year showed seventy-nine cases of dermatitis venenata in Boston, thirty-one in Philadelphia, and thirty in New York city. If the whole returns could be given, these figures would be much increased.

It was his habit to go to the vicinity of Long Branch every year, and he there saw a number of cases of dermatitis venenata. Last year he saw a boy with an eruption on the hands, arms, and face, in which the bullæ were of enormous size—larger, he thought, than he had ever seen before in such cases. At previous meetings he had spoken of dermatitis from iodoform. Since the last meeting he had seen a case sent by a physician to him for diagnosis. There was a dermatitis extending up the arm from the hand. This person had had an injury about the nail. He had already stated his opinion that there was something peculiar in crushing injuries about the nail which favored the development of iodoform dermatitis. Iodoform had been constantly applied in this case to the finger, and had resulted in quite a severe papulo-vesicular eruption. He had seen an eruption among workers in paraffin, and had been told by the men that many of the workmen suffered from this complaint, which among them was known by the name of "wax boils." Sometimes the eruption seemed to be due to the heat as well as to the effect of the paraffin.

Paget's Disease of the Nipple.*—Dr. George T. Jackson, of New York, reported such a case in a woman, fifty-two years old. She had had two children, the younger being born twelve years before the occurrence of the disease. She had had no trouble with the nipples during the nursing of either of the children. The disease began like an ordinary case of eczema and was so treated. Under simple treatment the disease apparently yielded, but in about eight months she came again with well-marked signs of Paget's disease. Within four months from the time she was seen a second time, the disease having progressed in spite of treatment, amputation of the breast was advised, and the operation was successfully done. At the time of amputation the nipple was retracted, there was an area of erosion about the nipple occupying the site of the areola, and a tumor could be felt in the breast. After amputation the breast was submitted for examination to Professor J. S. Ely, who found all the usual lesions of Paget's disease. The pathologist thought it likely that it was secondary to the breast tumor, which was of the fibroma type. The patient was seen about nine months after the operation, and showed no sign of a return of the disease. A tumor was found in the other breast that the patient stated had been there many years. Dr. Jackson urged the advisability of amputation of the

* Published in Journal of Cutaneous and Genit -Urinary Diseases, November, 1896.

breast in all these cases as soon as a diagnosis was made, on account of the tendency of the disease to the development of cancer, and because of the well-recognized intractability of the disease to all kinds of treatment, even to the most energetic by means of caustics and the curette.

DR. FORDYCE said that Dr. Ely's views, quoted in the paper, were very interesting, but they were so radically different from those generally received that they should be confirmed before being accepted unconditionally. This report indicated that fibrous tissue was present in the gland first, and that the disease probably began secondarily in the nipple. There appeared to be no connection between the previous disease of the gland and the change in the epidermis and the cutis. Most of the text-books teach that the disease begins in the epidermic cells, resulting in a peculiar degeneration of the protoplasm of the cells, simulating cell inclusions or psorosperms, and that the disease extends along the galactiferous ducts. The observations given in the paper were interesting, and might throw some light on the pathology of this disease.

DR. BOWEN said that he agreed with Dr. Fordyce in his criticism of the view of the pathologist.

DR. FORDYCE remarked that he had a section from Dr. Jackson's case which he would demonstrate at a subsequent session.

DR. DUHRING said he desired to speak concerning the history of the disease. Of late he had not chanced to meet with this disease, but in former years he had seen some cases, and had reported three of them. It seemed to him that in the histopathology of this disease much depended upon the stage at which it was examined. It usually manifested itself in the form of an inflammation of the corium at the outset, which clinically we were unable to differentiate from chronic eczema. It was in most cases in the beginning probably an eczematous inflammation. The same patient in whom we might diagnose an eczema this year, might present herself or himself from two to five years hence, when we might make an entirely different diagnosis. He believed that different pathological changes were apt to take place during such long periods, and that when seen for the first time in the later stages, one would be inclined to express the view that the disease was epitheliomatous. At this period the chief signs of eczema had disappeared, and a new process—a distinctly epitheliomatous one—had taken its place. He, therefore, found it impossible to believe that the pathology of the disease was the same at the beginning as at the end. His clinical observation and reading had led him to this conclusion. Clinically, it was a distinctive affection, known generally as Paget's disease, but as this process went on, he believed, in the vast majority of cases, it became epitheliomatous, presenting at the same time an eczematous aspect. For these cases, after the disease had fully developed, he would suggest the

name "eczematoid epithelioma." The case reported in the paper just read was certainly a peculiar one, and was different from the majority of those hitherto reported.

Dr. White asked if any examination had been made as to the nature of the tumor before the operation—particularly as to the superficial changes in the skin. He also wished Dr. Jackson to state what were the cutaneous changes found by the pathologist, and if they showed epitheliomatous transformation.

Dr. Jackson said that apparently the changes were those of chronic inflammation.

Dr. White said that this case could not then be strictly considered, either clinically or pathologically, as one of Paget's disease. After the persistent use of the usual applications in such cases, if no benefit were derived, we were inclined to look upon them as examples of Paget's disease. Under such circumstances it was justifiable to recommend excision of the disease, owing to the liability to the development of epithelioma in time. It seemed to him, however, that as this case had not eventuated in an epitheliomatous condition of the skin, it would be a mistake to class it under the head of Paget's disease.

Dr. Fordyce said that the histological appearance of the skin corresponded exactly with that found in Paget's disease. It was not necessarily a malignant disease of the skin at all, but of the breast. The changes in the cells in this case were those found in Paget's disease, and not those found in eczema.

The President said that he could not see that any connection had been positively shown between this tumor in the breast and the changes in the nipple. It might have been a fibroma, deeply seated, and the combination of disease of the nipple an accidental one. The pathology expressed in the paper was against all our previous ideas, and he believed it would prove to be erroneous. Too many histories had been reported in which the disease had been on the skin for fifteen or eighteen years before the gland had been deeply involved; hence, in these cases at least, the change in the nipple could not have been secondary. He recalled a personal case in which there was carcinomatous disease of the breast and secondary glandular affection preceded by the condition of the nipple found in Paget's disease. In this case there were one or two things different from those given in the description by Wickham. The margin was absolutely level with the surrounding normal skin, and there was not the first sign of an hypertrophied epidermis at that place.

Dr. Jackson, in closing, said that he was sorry that Dr. Ely, the pathologist, was not here to defend his views. He would say that had Dr. White seen the case, he felt sure that he would not have hesitated to make the diagnosis of Paget's disease, for the clinical appearance and course were typical.

Case of Symmetrical Morphœa, attended with the Formation of Bullæ and Extensive Ulceration.*—By PRINCE A. MORROW, M. D.

After referring to the statistical frequency of morphœa and scleroderma in this country, Dr. Morrow reported in detail a case of morphœa at present under his observation which was remarkable for the number and size of the plaques, their symmetrical distribution, the occurrence of bullæ, and the extensive breaking down and ulceration of some of the patches.

The patient was a man, sixty-six years of age, who had always enjoyed excellent health with the exception of attacks of inflammatory rheumatism. One year ago (September, 1895) the first patch appeared upon the anterior surface of the right thigh. Similar patches were soon observed upon both right and left thighs and over the tibial regions. In January, broad, bandlike patches appeared upon the lower abdomen, the sides of the trunk, on the back between the shoulders, and along the spine. These patches were quite symmetrical in form and disposition. Over the region of the right thigh, extending down nearly to the patella, they have become confluent and form a continuous sheet, completely investing the limb in its upper and middle thirds. On the left limb they are for the most part discrete. They present a white, lardaceous appearance, slightly elevated, and each surrounded by a well-defined lilac border. To the feel they are hard, rigid, and unyielding; the integument can not be pinched up. The white surfaces are stippled over with numerous punctiform indentations corresponding to the follicles of the skin. There is complete absence of hairs from the affected surfaces, with suppression of the sudoral and sebaceous secretions. Sensation is but slightly impaired.

In December or January the affected surfaces below the knees became ulcerated; the ulcerative process extended above and into the right popliteal space. Cicatrization of those surfaces did not take place until late in the present summer. A noticeable feature was the formation of numerous bullæ of the size of a marrowfat pea or larger, which upon rupturing would discharge an amber-colored fluid, leaving superficial excoriations which would heal in a few days. These blebs would occur here and there upon the cicatricial area without assignable cause. Their occurrence has been a constant feature for the past two or three months.

Under large doses of iodide of potassium and the thyroid extract there has been a notable and steady improvement. Within the past month salicylate of sodium was substituted for the iodide. The skin has lost its boardlike hardness and many of the patches are undergoing involution.

DR. WHITE said that the case reported seemed to be a very typical

* Published in November, 1896, number of the Journal of Cutaneous and Genito-Urinary Diseases.

one. He still held that the term morphœa was a useful one, and that there were many cases which had no relation to typical scleroderma. He preferred to recognize a state of the skin which might be well expressed by the term morphœa, which was liable to great variations, and which was quite distinct from scleroderma, a disease which varied but little.

Dr. Duhring said that he had been particularly interested in this subject for very many years, chiefly for the reason that in the earlier years of his practice he had chanced to meet with many cases of morphœa—more, he believed, than fell to the lot of most observers having an equal experience with skin diseases in general. He had probably seen, especially many years ago, twenty or thirty such cases; some slight, others severe. During the last ten years he had not seen so many as formerly, but quite enough to give him a great interest in the whole subject of morphœa, its pathology and its differentiation from scleroderma. For many years he had believed himself to be one of the few dermatologists of the world who believed in differentiating morphœa from scleroderma. He had taken this ground early in his publications —e. g., in his Treatise on Diseases of the Skin, published twenty years ago. He was, therefore, much gratified to hear Dr. White say that he took the same ground—i. e., that it was well to differentiate morphœa from scleroderma. Clinically, in many instances, these diseases presented entirely different features, so that it was possible to write essays on morphœa and scleroderma which would lead any reader to recognize the marked difference between them in most cases. He was well aware that the two conditions at times merged into each other and occurred together, but in most instances they appeared to be clinically entirely distinct. He believed, however, that their general pathology was similar. He had observed probably only about half a dozen cases of scleroderma. He had noted a severe case of scleroderma under his observation for the last two years, which possessed no symptoms of morphoic patches at any time.

The case presented by Dr. Morrow was a noteworthy one, and showed typical morphœa. It was also remarkable in being extremely generalized, and in the patches being unusually large. Many years ago he had seen in a rather notorious, very stout Irish woman a typical example of morphœa. From the nape of the neck down over the dorsum there were very large patches, quite as extensive as those shown in Dr. Morrow's case. This case illustrated the largest patch of morphœa that he had ever seen. The case just presented by Dr. Morrow was both interesting and instructive; it was an example of typical morphœa in contradistinction from scleroderma. It possessed none of the features of scleroderma. As Dr. White had said, morphœa often presented extraordinary deviations from the type, but nevertheless it held close to the chief characteristics of the disease. He had seen a few cases of morphœa

with ulceration. A reference to the pathology would show that ulceration ought not to be a very rare concomitant symptom of the disease.

DR. MORROW, in closing, said that he had removed two sections from this patient, and Dr. A. R. Robinson had kindly undertaken to make a microscopical examination. He had received a preliminary report from him, but had not read it because Dr. Robinson desired to make a more complete study of the subject, the results of which would be published hereafter.

A Peculiar Affection of the Mucous Membrane of the Lips and Mouth, with Colored Drawings and Photographs.*—DR. J. A. FORDYCE, of New York, reported a case in which the mucous membrane of the lips and inner sides of the cheeks was the seat of numerous, closely aggregated miliumlike bodies. The affection began two years before he came under observation, and has progressed in a symmetrical manner since that time. On superficial examination the normal vermilion color of the affected region seems to have been replaced by a light yellow tint. When the parts are made tense, however, the individual granular lesions are plainly visible. A portion of the diseased tissue excised from the oral cavity for microscopical examination showed a degenerative process in the protoplasm of the epithelial cells. The muciparous glands were not involved.

DR. MORROW said it was of interest to know that a similar condition had been found among so many members of the same family. When he had at first observed the condition in this patient, he had been at a loss to explain the nature of the affection; indeed, he thought it could be done only by microscopical analysis.

DR. WHITE said that he had occasionally seen superficial changes in the lips suggestive of the case just reported, but he must confess that he was ignorant of the nature of these changes.

DR. BOWEN asked if Dr. Fordyce had determined the nature of the white bodies. He thought the condition might be explained by a plugging up of the gland by this perverted process of cornification. He had recently seen a case of long-continued bullæ followed by atrophy, and this atrophy had caused the formation of similar bodies as a result of a plugging up of the glandular structures of the skin.

DR. FORDYCE said that he would exhibit the specimen under the microscope along with the demonstration of other specimens.

DR. ALLEN said that he had not been consulted by any individual for this condition, but he thought he had frequently observed it in persons, and to such a degree at times as to be almost a deformity.

A Favuslike Eruption of the Oral Mucous Membrane caused by the Aspergillus Nigrescens.—By JAMES M. WINFIELD, M. D., Brooklyn.

The patient was a healthy female, aged twenty-seven years. Early in November, 1895, she noticed a "small ulcer" on the roof of the

* Published in the November, 1896, number of the Journal of Cutaneous and Genito-Urinary Diseases.

mouth. This gave so little discomfort that at first she paid no attention to it. It was not until the patch began to enlarge that she consulted her family physician. He at first thought the trouble was from some digestive disturbance, and treated her accordingly. It not yielding, she was put on a thorough course of antisyphilitics, but with no benefit. The writer was then consulted. The appearance of the mouth was as follows: On the left side of the roof of the mouth there was an œdematous and lumpy patch covered with a slightly adherent membrane, the color of which suggested the yellow scutula of favus.

Microscopical examinations were made of a piece of the swollen tissue, and cultures were taken from the scrapings of the patch; both of these methods of examination showed the presence of the fungus known as the *Aspergillus nigrescens*. Local applications of a mild caustic were made to the patch, which seemed to retard the growth of the fungus for some time. After a while, however, the roof of the mouth became more thickly studded with fresh patches. Then treatment was changed to the peroxide of hydrogen; this finally effected a cure.

Dr. Bowen asked if there were any record of pathological lesions produced by this form of aspergillus.

Dr. Winfield replied affirmatively, stating that it was the same growth that was frequently found in the ear.

Dr. White asked if this patient were accustomed to breathe through the mouth.

Dr. Winfield said that he had inquired about this point, and had found that the person was not a mouth-breather, and also that the growth did not extend beyond the palate.

Dr. Duhring said that he thought all would agree that it was an extremely rare case. He certainly did not recall having seen such a case. He would like to ask whether the lesions were adherent, or were easily removed by scraping.

Dr. Winfield said that considerable force was required to remove them, and that this was followed by a little bleeding.

Dr. White asked if any iodine applications had been made.

Dr. Winfield replied that tincture of iodine had been applied, but with no benefit.

What Effect do Diet and Alcohol have upon the Causation and Course of the Eczematous Affections and Psoriasis?—Dr. James C. White, of Boston, opened the discussion.

In 1887 I presented a paper to this association entitled An Introduction to the Study of the Influence of Diet in the Production and Treatment of Skin Diseases, in which I tried to show upon how inexact and unscientific a basis any opinions upon the subject held by patients, general practitioners, or even dermatologists rested, and how useless would be any discussion upon it until the methods of observation and deduction were radically changed. How far does the criticism then expressed

still hold true? With how much more exactitude and advantage can we approach the consideration of the question in its more restricted scope to-day? I am not aware of any systematic investigation carried on by any dermatologist in a scientific spirit or method since the above date, and until the subject has been thus broadly and closely studied its discussion can be hardlly other than more or less positive statements of individual impressions, widely variant, no doubt, as heretofore.

I could not perhaps state my present views better than by reading again my former paper.

Of course we all recognize the influence of certain articles of food on the condition of the skin. These disturbances are both direct and indirect. The direct are mostly fugitive in character, forms of erythema and urticaria, with or without apparent concomitant gastric disturbances. They are largely idiosynerasic. The indirect are produced by the impairment of general nutrition through a too restricted selection or improper or badly prepared articles of food, or those containing toxic properties, of which scorbutus and pellagra are examples, the skin sharing in the impairment of all the tissues of the body. Overeating and "dieting" are both factors of such indirect disturbances. There are many fallacies about specific articles; the more fixed and positive the belief about them, the more unfounded are they, as a rule.

ECZEMA.—The influence of diet on its causation.

Food.—Inferences to be drawn from national dietaries.

The consumption of meat in England, according to Walter Smith, is one hundred and thirty-six pounds per annum per head; in France, only forty-six pounds. In certain nomadic tribes the diet is largely animal. In certain great sects it is largely vegetarian. In some maritime nations the diet is largely fish. In great inland regions no fish is eaten.

Now, so far as we know positively, there is no difference in the prevalence or course of eczema, with or without treatment, among such nations.

Inference from Individuals.—Men eat far more meat than women and children, yet the prevalence and course of eczema is the same in these classes. In infancy, under simplest and most uniform diet, there is most liability to and obstinacy of the disease.

Therapeutic Test.—Rarely, if ever, properly applied; if not, it is wholly useless. It must be used on an extensive scale and exclusively of other treatment.

Under my experience eczema is easily provoked, often aggravated by certain acid fruits. I recognize no other article of diet capable of producing specific action on causation or course.

I admit also injurious action upon the course of the disease of articles which overstimulate cutaneous circulation, or which excite the nervous system and thus aggravate pruritus.

I would make diet in acute eczema the same as in all other inflammatory processes.

I recognize no proved connection between eczema and any so-called diathesis, and therefore deny the efficacy of systems of diet devised for prevention or cure of such real or imaginary conditions.

Alcohol.—Whole nations use none, others in great moderation. In childhood and some individuals total abstinence is observed. Great variation in form employed among different peoples—men take much, women little. Has there been any demonstration that the prevalence of eczema is affected by such extreme variations? I have no knowledge of such. I do not regard it as an important factor in causation of eczema.

Upon the *course* of the disease I recognize an influence, both direct and indirect, by its immediate power of setting up a specific dermatitis and of aggravating any existing one, and its eventual action upon all the functions and tissues of the body when used in excess.

Psoriasis.—Its association with eczema in the question formally before us for consideration I take to be wholly arbitrary. They are such entirely different processes that they should be studied in relation to our immediate points of inquiry apart from each other. In my opinion we are absolutely ignorant with regard to the ætiology of psoriasis, beyond its recognized exceptional relation to hereditary influence.

I may state the results of my own observations very briefly. Diet and alcohol have no influence upon the causation or course of the disease in general, but in exceptional inflammatory crises or types they become of temporary importance. I have read very positive statements that the disease may be cured by the exclusive use of animal food, and as strongly expressed convictions that it may be cured by a purely vegetarian diet. Both claims were substantiated by series of cases. Do they not balance each other? It may be held by some of my colleagues that the sides taken by those who are to speak upon the question before us are determined by our respective views regarding the so-called constitutionality of these two affections, or, on the other hand, that some light may be thrown upon this disputed point in pathology by inference drawn from the influence of diet and alcohol upon their causation and course, but I do not see that any such conclusions are warrantable. Any definite and positive knowledge of the real nature of these affections has yet to be determined by unbiased observation, and their successful treatment remains, as heretofore, a matter largely of empirical experimentation.

Dr. Fordyce continued the discussion. He said that he did not think we had any definite proof of the influence of diet and alcohol upon either eczema or psoriasis. In his opinion, eczema was a general term including many different conditions. Thus, in infancy, the tendency to eczema was largely due to the delicacy of the skin at that period of life. At present, our ætiological knowledge was so meager that it was difficult to express any definite views on the influence of diet and

alcohol on these affections of the skin. A study of the natural history of psoriasis would, perhaps, explain the divergent views regarding the supposed causative influence of alcohol and food on this affection. In the early stage, when the disease was progressing, he thought its development might be influenced by alcohol, and perhaps also by food. In the stage of decline, the disease at times appeared to be favorably influenced by various drugs and foods.

DR. JACKSON said that it had always seemed to him that alcohol aggravated eczema and psoriasis. Opinions were constantly changing in regard to eczema. We have to allow the influence of micro-organisms in the production of certain forms of this disease. It had always seemed to him that the general condition of patients with eczema and psoriasis, as well as with other diseases of the skin, should be considered first apart from their skin affection, and, if any form of diet was necessary to correct any condition present, to adopt it. As a general rule, the more simple the diet could be made, the sooner would the patient regain his normal power of resistance and recover from the disease. He had seen cases treated with all sorts of exclusive diets, and he had been unable to observe any great difference in their action. It was, he thought, after all, the simplicity of the diet which was of prime importance. We could not as yet speak authoritatively on this matter.

DR. DUHRING said that the matter was so broad in its scope that it was necessary to confine one's remarks to certain points. In his opinion, there was a vast difference between food as a cause of disease and food as an injurious factor in disease. He would, from his own experience, question very much whether food could be regarded as a cause of eczema, except in rare cases, but that it possessed in many instances a direct injurious influence upon the disease, he had no doubt. Apropos of the statement made by the last speaker regarding our vague notions of eczema at present, he would say that it seemed to him that, on the contrary, our knowledge of eczema was more clearly defined now than it was twenty-five years ago. He agreed with Dr. White that where eczema and psoriasis were associated it was generally an arbitrary occurrence. For this reason it was difficult to discuss the influence of food upon eczema. In many cases of eczema food appeared to decidedly aggravate the disease when it already existed. It seemed to him that food had much less influence over psoriasis than over eczema; but here, again, individual cases must be taken into consideration. He recalled the case of a gentleman, an old physician, seen many years ago, who was the victim of a severe psoriasis, which was in no degree controlled by either internal or local treatment. The disease was so severe that he had been confined to bed for many years. This patient conceived the idea that diet ought to have some distinct influence on the disease in his case, and he was in communication at that time with Dr. Passavant, of Frankfort, Germany. The latter, after having been hopelessly affected by psoriasis for a long

time, had been finally cured by an exclusive diet of meat for six or eight weeks. The gentleman first referred to also adopted the exclusive meat diet, but at the end of six weeks was in no wise benefited, and subsequently the same result followed an exclusive vegetable diet for six weeks. He was then carried on to an ocean steamer, and took a voyage of ten or fifteen days, employing a mixed diet. He had only been on the steamer three days when an improvement was noted, and at the end of the voyage there was but little of the psoriasis remaining. No medication of any kind was adopted during the voyage. He traveled over Europe for several months comparatively free of disease of the skin. Subsequently he had several slight relapses of psoriasis. He was, therefore, practically cured by an ocean voyage and without any medication whatever. Such cases surely merit attentive consideration.

Dr. Duhring further said that he did not believe alcohol exerted much influence in the causation of the diseases under discussion. All would admit, however, that in many instances it was highly injurious, but it was far from being such a potent factor as food.

Dr. Isadore Dyer, of New Orleans, said that he had repeatedly watched recurrent cases of infantile eczema, attacking particularly the extensor surfaces, and notably the face. In every instance he had investigated the dietary, and had found in most instances that it was at fault. Without any internal medication whatever, and with both careful and indifferent local treatment, he had promptly effected a cure by a proper regulation of the diet. He could not, of course, speak so positively regarding the action of food in causing eczema. It probably acted as an ætiological factor by causing intestinal fermentation.

Dr. Morrow said he was inclined to agree with Dr. White that food had very little effect in the causation of diseases of the skin, especially eczema and psoriasis. He had noted in the dispensary and hospital practice in the Hawaiian Islands that eczema and psoriasis were almost exclusively the skin diseases met with, with the exception of a few parasitic skin diseases. It should be noted that they were extraordinarily frequent among a people who lived almost exclusively on a vegetable diet. These people very rarely tasted animal food. He did not think we could attribute any marked influence to diet in the causation of these diseases, although he was prepared to admit that improper diet might have a marked influence on their course. As Dr. Dyer had just stated with reference to infantile eczema, he had found, on investigating the food of infants affected with eczema, that a certain proportion of them suffered from what might be termed malassimilation. Many of them were taking food which was either deficient in quantity, or wanting in the proper elements of nutrition. Some of the children, it was found, were allowed to take coffee, vegetables, and meat, or anything on the parents' table. He had found that by correcting these faulty conditions of nutrition the eczema was markedly improved. Regarding the effect of diet

upon the *course* of these diseases, it seemed to him impossible to determine with absolute accuracy the effect of the therapeutic agents and that due to the modification of the diet. In his dispensary practice he was always accustomed to give certain prescriptions, but no specific directions regarding the diet, knowing that they would not be observed. On the other hand, in private practice he was accustomed to recommend that a small proportion of red meat be taken, with plenty of fresh vegetables and milk, with the avoidance of fried articles of food and of sweets. Certainly the private patients did very much better than the dispensary patients, but it should be remembered that the local treatment in this class was also carried out much more efficiently than in the former.

Regarding the effect of alcohol, he believed that owing to its influence on the circulatory apparatus of the skin, it had the same injurious action in eczema and psoriasis that it has in syphilis. It was well known that alcoholics, as a rule, were more liable to suffer from the severer type of syphilis. During a long experience in the dermatological department of the Charity Hospital he had been impressed with the large proportion of psoriasis cases—perhaps eighteen out of twenty beds. Many of them were old stagers. The psoriasis would be cleared up by proper local treatment and the patient sent out, but if the patient went on a spree, as he often did, the psoriasis would promptly return. It seemed to him that whatever might be the influence of alcohol in the causation of psoriasis, we must certainly recognize its influence in favoring relapses. It would be found, as a rule, that alcoholic patients with psoriasis proved the most refractory to treatment.

DR. C. W. ALLEN said that the experience at Charity Hospital referred to by the last speaker reminded him of his own experience at that institution. He had also found that psoriasis occurred very largely among the alcoholics, and that the disease very quickly recurred in an aggravated form when, once freed, the patient went out and indulged. It was his belief that alcohol had a great deal to do with this recurrence in view of the fact that these persons often had little or no special treatment for some time prior to their discharge from the hospital, so that it could not be attributed to stopping drugs. In his opinion, alcohol influenced the course of psoriasis more than did food. With the exception of infantile eczema, the converse of this might be considered as true. He agreed with Dr. Dyer's statement regarding facial eczema in children. In his dispensary experience, children who were allowed a wrong and mixed diet—a diet often including tea and beer—were very liable to eczema, and the disease was aggravated by such diet.

The PRESIDENT said that we all recognized the fact that the molecular constitution of our protoplasm depended upon the kind of food we took. For instance, if we lived only on mutton for a number of weeks, our molecular constitution would be different from that following the use of a mixed diet. Now, if it were admitted that eczema and

psoriasis were almost invariably, if not always, parasitic diseases, and that furthermore the organisms require a special ground for their proper growth, the question would naturally arise as to whether alcohol or certain foods furnished a favorable soil for their development. While food would not be a direct exciting factor of gonorrhœa, for instance, yet every one must admit that a gonorrhœa could be cured with difficulty if the patient persisted in drinking much alcohol, or ate such foods as would keep the urine acid. He had had an unusually large experience with sick children. Their eczematous diseases could be divided into two classes—the toxic and the parasitic. There was perhaps no direct toxic agent, but the ground was made favorable for such organisms as reached the surface directly. In forms of indigestion, particularly stomach and small-intestine fermentation dyspepsias, certain toxines are formed, and in this way a toxic eczema might be produced through the nervous or circulatory systems. In his experience, the sugars had been found to be particularly injurious. This was a common experience in children affected with facial eczema, and who were given cheap candy to eat. Correction of the intestinal disturbance would, as had been mentioned, almost invariably lead to a disappearance of the eczematous eruption, although much more slowly than if a local application were also used. If a local application were used which would tend to make the ground unfavorable for the development of parasitic organisms, even if not a direct antiparasitic agent, the progress of the case would be much more rapid. Such an application need not be a direct antiparasitic, but some mild application, such as boric acid. Certainly, when the inflammation had once arisen, the diet must be considered an important factor in the management of the case.

Dr. White had stated that we had no demonstration of a direct connection between gout and rheumatism and such diseases as eczema and psoriasis, but he thought it would be admitted that the gouty person was pretty sure to get an interstitial nephritis sooner or later, and believed the same agent could cause a dermatitis when excreted by the sweat glands. Urate of sodium had been found upon the skin in cases of gout, and he could recall a case in which all the usual internal and local treatment for the eczema had been unsuccessful, but in which an internal treatment directed to the gouty condition alone promptly removed the eczema. He had at one time shown such a case before the New York Dermatological Society. He thought Dr. Duhring would remember another similar case in a well-known public man, as both had been called in consultation in the case, an unusually severe and obstinate case of eczema, which was evidently dependent upon a gouty condition which could not be removed, and the disease proved incurable from all local and general treatment.

Regarding psoriasis, the speaker said that certain foods had much influence, but their injurious action could be counteracted by appro-

priate internal medication. In psoriasis he endeavored to maintain an alkaline condition of the system by diet and drugs, and gave arsenic for a more or less specific effect on the lesions. As long as the urine was acid he was unable to successfully treat such cases, but if the urine could be kept alkaline the case would almost invariably respond to proper doses of arsenic. Much less alkaline medication would be required, however, if the diet were properly regulated. He had seen a case in which a man after a number of months of general psoriasis and judicious local treatment recovered on a diet of only milk and Vichy water. Cases are often seen in which the eruption will disappear perhaps for three or four months, and then after indulgence in wine or beer there will be a sudden and extensive eruption of the psoriasis. This certainly led one to think that alcohol had some effect, if only to make the ground favorable for the micro-organisms.

DR. WHITE, in closing, said that the president's remarks were largely based upon the supposition that eczema was a parasitic disease. He did not think, however, that we had any positive knowledge that it was a specific parasitic affection. At present, in his opinion, this was merely a theory. He would not, of course, deny Dr. Robinson's results.

With regard to the remarks made upon eczema in children, he would say that it should not be forgotten that children were born into this world with the skin entirely free from eczema, and after nine months of intra-uterine life in which they had been fed upon nourishment derived from the mother. During this time the skin had been exposed to the liquor amnii, so that in one sense it had had a local treatment. Now, eczema occurred most frequently in the first year of life, when the food was the simplest and most uniform in character. Each year up to the tenth—in other words, while the complexity of the food was continually increasing—eczema became less frequent. These were facts. If Dr. Dyer had told us that the regulation of the diet had been followed by certain results, without any local treatment, then he might be inclined to draw more serious conclusions from his statement. Personally, he did not use any internal treatment in infantile eczema, although, of course, he did use local treatment, as did Dr. Dyer.

DR. DUHRING said that he desired to supplement his remarks by saying that food influences the nutrition of the skin in some cases of eczema in a notable degree, and that hence it must be regarded as an important factor in the history of eczema.

Mycosis Fungoides and Sarcomatosis Cutis.—By DR. JOHN T. BOWEN, of Boston.

DR. BOWEN described two cases that he had observed and studied, which illustrated the difficulty that may in some cases be met with of differentiating mycosis fungoides from sarcomatosis cutis. These cases offered support to the theory that has been advanced by Kaposi and others that there are transitional forms between these two types of dis-

case. He believed that in the present state of our knowledge it was impossible to class mycosis fungoides either with the granulation tumors, sarcomata, or lymphomata, although its relationship to these affections should be constantly kept in mind. He related further two typical cases of pseudo-leucæmia in which nodules resembling those of prurigo Hebra were present on the skin. He had made a careful histological examination of one of these nodules, and found that the structure was identical with that described by Leloir and Kromayer as occurring in true prurigo nodules. This would tend to disprove the theory of Josef that we have here to do with leucæmic tumors.

Dr. White asked how large these nodules were, and whether he was speaking of large papules, or the secondary large nodules occasionally developed in prurigo.

Dr. Bowen said that he had referred to the true prurigo papule.

Dr. White said we must regard the fugitive character of these lesions as common to both mycosis and sarcoma; certainly the many hundreds of nodules, varying in size from that of a pea to that of a pullet's egg, occurring in multiple sarcoma and which disappeared in a few weeks, in some instances under arsenic, were as fugitive as if they disappeared without treatment. Although there was a great difference in the maximum size of such lesions in these two affections, it was only a matter of degree. A nodule the size of a pigeon's egg would disappear rapidly in the one case, and a nodule the size of a goose egg would disappear rapidly in true mycosis fungoides. How far it indicated any common nature he was unable to say.

Dr. Duhring said that he was much interested in this paper, for the reason that he had had an opportunity of seeing during the past fifteen years a number of cases of "mycosis fungoides." He objected to this latter term, although he was aware that it was generally applied to this disease by most authors. He considered it a misnomer, and preferred the term "granuloma fungoides." The term "mycosis" had been applied because it had been thought that it was of a mycotic nature, but especially because it resembled fungi in its gross appearance. The term "fungoides" he did not consider objectionable. He had been asked not infrequently by medical men to describe or to demonstrate the fungus of this disease, because from the name mycosis it must surely be mycotic. The instances of granuloma fungoides that he had met with had all been typical, so that sooner or later almost any physician could have readily made the diagnosis. The latter was easy in most instances after the disease had become fully developed. It was different from sarcoma of the skin in the majority of instances. He had seldom met with cases of multiple sarcoma of the skin in which the condition was liable to be confounded with granuloma fungoides. As to the histological condition found in the two types he was free to admit that there was much confusion, and he was not prepared to distinguish clearly

between the two. It seemed to him that the inflammatory element was distinctly more marked in granuloma fungoides. In the earlier reported cases of granuloma fungoides—among them one case reported to this association by him eighteen years ago—the inflammatory symptoms were throughout the course marked, much more so than he had ever observed in multiple sarcoma.

DR. MORROW said he would like to ask in which category Dr. Duhring would place the two cases reported by Dr. Bowen.

DR. DUHRING said that the first case was undoubtedly one of granuloma fungoides, but about the second he was not quite so sure.

DR. FORDYCE said that he thought it was sometimes very difficult to distinguish, as Dr. Bowen had said, between mycosis fungoides and sarcomatosis. There was nothing very distinctive in the pathological anatomy of mycosis fungoides and certain forms of sarcomatosis. It was well known that there were types of spindle-cell sarcoma which could be differentiated by the microscope, but mycosis fungoides and multiple sarcoma of the Kaposi type and certain other forms could not always be well distinguished, and it was not at all improbable that some of these had different causes not yet well understood.

DR. MORROW said regarding the difficulty of differentiating these diseases by the pathological findings, that some years ago he had had a case of very typical mycosis fungoides with characteristic tumors over the body which had passed through a long pre-mycosic stage. During this period the case had been under the observation of several physicians, who treated it for eczema, in the lichenoid stage. Dr. Elliot had excised one of the small lesions, which exhibited the microscopic characters of epithelioma. This was before the development of the typical tumors of mycosis fungoides.

The first case reported in the paper under discussion was undoubtedly one of mycosis fungoides, although it seemed to him unusual that the disease should begin in the testicles as had occurred in both cases. In several cases he had noticed an exemption of the testicle from implication. When the tumors developed without a pre-mycosic stage, it was generally recognized that the prognosis was bad, and that the termination was more apt to be speedily fatal. He had had a case which had existed in the pre-mycosic stage for six or eight years without any serious impairment of the health.

The PRESIDENT said that he could not accept the statement that the disappearance of the tumors should exclude the term sarcoma. He looked upon sarcoma as being very rarely a new growth, a simple tumor in the proper sense of that term as used by Cohnheim. The growth of these tumors is never associated with the production of an agent injurious to surrounding tissues. When a tumor, like a sarcoma, arises and disappears as it sometimes does, this should be sufficient to exclude it from the term "simple tumor." He had seen malignant epitheliomatous

tumors disappear without any treatment whatever, thus proving to his mind that they were not simple tumors. Wherever there are inflammatory changes he would be inclined to regard it as probably dependent upon some organism. The term "sarcoma," like the term "eczema," is a very indefinite one and includes somewhat similar pathological conditions caused by a number of unknown and different factors. He did not think that certain cases of mycosis fungoides could be differentiated from a sarcoma, certainly not from the pathological findings alone.

Dr. Bowen asked where the president would place the first case reported in the paper—the one which had been carefully observed and studied.

The President replied that he would certainly class it as a mycosis fungoides.

Dr. Bowen, in closing, said regarding Dr. Duhring's criticism of the term mycosis fungoides, that the name was not a good one, but it was the first name given it, and all the others had been representative of some pathological theory. Auspitz, for example, had concluded that the tissue represented an infective granuloma, and that it was due to an infectious process, and, hence, he called it "granuloma fungoides." But this was objectionable because it had not been shown to be an infectious granuloma. The French term, *lymphadénie,* tied one down to a distinct belief in its lymphatic nature, and hence was objectionable, as its lymphatic nature could not be proved. The term mycosis fungoides seemed to him provisionally the least objectionable term. He recognized cases of pure multiple sarcomatosis of the skin, and that there were different types. His first case seemed to be nearer mycosis fungoides than sarcomatosis, although the latter could not be very positively excluded.

A Pathological and Clinical Classification of the Diseases of the Skin.—Dr. Louis A. Duhring read an article on this topic, accompanying his remarks with tables showing the arrangement of the diseases of the skin according to the views expressed. The diseases were arranged in nine classes as follows: 1, anæmias; 2, congestions; 3, inflammations; 4, hæmorrhages; 5, neuroses; 6, hypertrophies; 7, atrophies; 8, new growths; 9, diseases of the appendages of the skin.

This classification is to a large extent the same as the author's earlier classification published twenty years ago, but it contains some radical changes, the more important of which are the omission of all ætiological factors and classes, and of the introduction of a comprehensive class devoted to the diseases involving the appendages of the skin, the sebaceous and sweat glands, the follicles, hair, and nails. This latter class is a useful one, and enables us to group many diseases that could not be advantageously placed elsewhere—as, for example, certain diseases of the hair and glands.

While an ætiological classification is ideal, experience shows that it is not practicable, from the well-known fact that one cause may pro-

duce several distinct diseases. The author expressed the view that for the purpose of studying the diseases of the skin it was essential that notice first be taken of the varied manifestations that occur on the skin, and that these be grouped according to the pathological, histo-pathological, and anatomical changes, together with the predominant clinical features, the latter being of aid to the clinician in diagnosis.

DR. WHITE said that he did not regard this classification as an improvement upon Dr. Duhring's previous system of classification. For instance, on examining his Class 3, one found many affections placed under this head which, in his opinion, might just as well have been placed elsewhere. The last page he considered a sort of *omnium gatherum*. He did not see why there should be such a class when many of those affections could be just as well included under other heads. Nor could he see how, in the present state of our knowledge, we could ignore the ætiological element in a system of classification; it seemed to him more important than an anatomical classification. Again, dermatitis herpetiformis was put down among affections characterized by vesicular and pustular lesions. He would say that urticarial lesions were quite prominent in a large number of cases of dermatitis herpetiformis, and some cases are exclusively characterized in prolonged attacks by simple erythema and urticaria. He had seen a number of such cases. Dr. Duhring, he saw, still preferred to consider pityriasis rubra and dermatitis exfoliativa as separate affections. The speaker said he would be unwilling to place tinea versicolor under the head of inflammations, for in at least ninety per cent of these cases there was no visible inflammation whatever. In exceptional skins, and in some seasons of the year, it was true some inflammatory conditions might be set up, but it was the exception and not the rule. Pediculosis produces inflammation in certain skins, but in others it produces no inflammation whatever. This is determined by the peculiar temperament of the individual. Advanced pediculosis might exist for long periods of time without exciting the skin to any degree. It would be vastly more useful to class together erysipelas and furunculosis—the coccus diseases—than to separate them as is done in this classification. Under the head of hypertrophies he found the term argyria, but he could not see how it could be regarded in any way as a hypertrophy—it was a foreign element introduced into the skin. Again, œdema neonatorum he would not regard as a hypertrophy; it was an oozing of serum, but without any tissue changes in the skin, except so far as the infiltration with serum or lymph. Atrophy, as a lesion, is not the early and essential feature of so-called xeroderma pigmentosum; the early symptom is pigmentation. He would hesitate about placing lupus erythematosus among the new growths of the skin; it did not seem to him to belong there.

In conclusion, Dr. White said that he was aware that these fragmentary remarks constituted an utterly inadequate criticism of such a

serious attempt at a new classification, but it was all the opportunity afforded him.

Dr. Morrow said that Dr. White had already called attention to certain features in Dr. Duhring's scheme challenging criticism, and in a hurried glance over the classification he had himself noted many of the same points. He thought all of us recognized that the ætiological classification of diseases of the skin was the ideal one, and therefore it seemed to be a step backward to entirely ignore the ætiological element in the attempt to construct a classification. Dr. Duhring had attempted what every one before him had recognized as an impossible task—i. e., a satisfactory classification of skin diseases. He thought it would be confusing to a student of dermatology to find tinea circinata and tinea tonsurans, which were due to essentially the same ætiological agency, classed under different headings; it would seem to imply their essentially different nature. Very often tinea circinata affected the follicular structures just as did tinea tonsurans, and there was no reason why they should not be classed together. The only motive for placing verruca necrogenica under dissection wounds would be on account of the mode in which the infection was communicated. The placing of molluscum epitheliale under the head of hypertrophies seemed to him questionable. Morphœa and scleroderma were classed as atrophies, although the primary and essential element was recognized in all cases to be a hypertrophy. In the case he had reported the lesions were disappearing without atrophy, and there was a distinct hypertrophy present.

Dr. Allen said that while at the present time, and for many years to come, it might be considered a thankless and even an impossible task to make a satisfactory classification, still he thought it was a reproach to American dermatology and to the association that we must rely upon an alphabetical list of skin diseases instead of having some kind of classification. But the argument that because we could not have a perfect classification, we should not have a classification at all, did not seem sound. He, therefore, thought Dr. Duhring had attempted a good work, and he hoped he would persist in his efforts to improve it. If we could get a classification which would be satisfactory enough for this association to adopt as a working basis, it would be very desirable. Of course, he did not like the grouping together of tinea tonsurans and tinea circinata and many other features that had already been criticised, for they certainly confused the student of dermatology.

The President said that he had studied this classification for an hour, and yet he still felt incompetent to criticise it. It seemed to him, as it had to Dr. White, that the classification would not be so useful to the reader, or for teaching purposes, as Dr. Duhring's original classification. It was certainly quite complicated. The attempt to arrange the diseases in this manner appeared to him a correct one, and worked out upon as good a basis as was at our disposal at the present time. Of course,

it would be better if we could have an ætiological classification, but this was impossible now, and probably would be in the future, for the reason that there were too many agents which were capable of producing very different pathological processes, and many different agents cause very similar ones. He noted that a number of diseases are classified as multiform exudative affections, and yet separated. Why they were not all included under one bracket was not apparent to him. The general arrangement seemed to him correct, but he thought the inflammatory exudations were too much divided up, and tubercular affections of the skin appeared to be very improperly spread into different groups, and hence gave rise to confusion. The classification showed much serious study, yet he must confess that it presented many objectionable features from the standpoint of usefulness.

DR. DUHRING, in closing the discussion, said that it would afford him infinite satisfaction to discuss this subject at length, as it was one in which he was deeply interested. He had given a great deal of time and thought to the matter of classification, and had laid out several entirely different classifications during the past twenty-five years for his own satisfaction. These had been based on different lines of thought, including one on the ætiological classification. He had, therefore, gone over the ground of classification of diseases of the skin in general a number of times, but had been working especially on the lines of pathology and histo-pathology and anatomy for many years, and had found such a classification more satisfactory, both to himself and to students, than any other. He believed that to-day such a classification was the best for the student beginning the study of diseases of the skin. It was the best classification by which a society could arrange the diseases met with clinically, and upon the whole, he thought that the basis of such a classification was the most scientific. The ætiological classification, which to the casual observer seemed so tempting and promising, could not be carried out to any extent in practice. Any one attempting to work upon this classification and handle a large amount of clinical material would soon find a number of diseases unprovided with a place. While, therefore, some diseases could be grouped very satisfactorily in an ætiological classification, the larger number could not be so classified. The obvious reason for this had been already touched upon by Dr. Robinson. For instance, quite an array of so-called diseases is caused by the trichophyton fungus. It was well enough for dermatologists—professors of dermatology—to have an ætiological group, but the student (finding perhaps half a dozen different clinical pictures due to the same cause) could not help being confused. He was of the opinion that every decade would find us further away from an ætiological classification for purposes of studying and grouping skin diseases. The placing of certain diseases of the skin in the class of hyperæmias or in inflammations was certainly far from perfect, and would probably be changed as our knowledge of

their pathology advanced, but for the present it seemed to him the best plan at our command. The weak point in the older classification of Hebra and in that of the speaker was that there was no place for many of the new diseases of the skin. The diseases of the appendages of the skin had been introduced because it gives a place for grouping conveniently a number of diseases which could not be placed elsewhere satisfactorily. To be consistent, we must forego certain things and accept others, though the scheme may not be wholly satisfactory. On the lines of consistency it would be improper to place tinea tonsurans with the "inflammations" when there existed a class for diseases of the hair follicles. In criticising a classification of this kind, the whole subject and its scope and purpose must be kept in mind. In some of the criticisms just made, it had been suggested to take certain diseases out of certain classes and arrange them elsewhere. This was all very well from one standpoint, but before taking them out of their present class one should know if a better place could be provided for them in this classification.

The question naturally arose, What constitutes a disease of the skin? Does it consist of certain changes in the skin irrespective of their cause? He would take the ground that a disease of the skin is made up of a variety of factors, of which the cause is only one, and therefore that the clinical history, the symptoms, the cause, the general pathology, and the histo-pathology, all go to make up a disease. He himself was positive as to the correctness of this view, but from what had been said by Dr. White and others he noted that all observers and authors were not agreed upon this point. In forming a new classification it was not well to depart too far from old and generally accepted lines. There were many diseases placed here and there in any classification because there seemed to be no better place for them. It was impossible to find a proper place for every disease of the skin that has been described. Allusion had been made by one of the critics to pityriasis rubra and its place in this classification. As ordinarily considered in recent literature, pityriasis rubra and dermatitis exfoliativa were considered as one and the same disease, but this was not his conception of them, although admitting that they were allied. He believed that he could show varieties of pityriasis rubra which no dermatologist would consider the same disease as dermatitis exfoliativa.

(*To be continued.*)

Selection.

An Oidium in the Tissues of a Case of Pseudo-Lupus Vulgaris. T. C. GILCHRIST and W. R. STOKES (*Johns Hopkins Hospital Bulletin*, vol. vii, No. 64).

In 1894 Busse published a case in which subperiosteal abscesses were found to be caused by blastomycetes, and in the same year Gilchrist exhibited to the American Dermatological Association sections from an apparently typical case of scrofuloderma, showing in miliary abscesses similar round, doubly contoured, and refractive bodies. These are the only reported instances previous to that which forms the subject of the paper.

The disease began as a "pimple" behind the left ear and spread peripherally forward very slowly, the older portions cicatrizing spontaneously. The healing process is only partial. In nine years the cheek, forehead, nose on left side, the right eyelids, brow, and cheek were successively involved. Other lesions appeared during this period on the back of the right hand, scrotum, and anterior surface of the left thigh above the internal condyle. The disease presents a distinctly marked border, consisting of a comparatively thin (one third inch wide) inflammatory ulceration, superficial and lightly crusted over. The area inclosed consists of a continuous atrophic scar. The disease is not painful. There are no enlarged glands, and the health is good. Various forms of skin tuberculosis were thought of and abandoned.

Microscopically, the epidermis is hypertrophied, studded with miliary abscesses, and infiltrated with leucocytes. In the derma were found a number of tuberclelike nodules. In these and the abscesses numbers of round, doubly contoured, and refractive bodies, 10 μ to 20 μ in diameter, appeared. Cultures were taken from the pus, from under the scabs, and from fresh sections, and grew most favorably on glycerin-agar and potato, but were slow in developing. The morphology was studied from young colonies. The individuals presented the appearance described, increased by germination, and formed short hyphæ. From the mycelial threads buds were put out, and formed conidia, which remained attached or were freed. Animal inoculations were made successfully in the case of a dog whose lungs were the seat of nodules containing the organism, of which pure cultures were obtained and other inoculations made. The parasite failed to cause alcoholic fermentation, and this, with its morphological characters, classes it as an oidium, a subdivision of true fungi, and separated from the yeast plant. J. C. J.



DR. MORROW'S CASE OF PREFUNGOID STAGE OF MYCOSIS FUNGOIDES.

JOURNAL OF
CUTANEOUS AND GENITO-URINARY
DISEASES.

Vol. XIV. DECEMBER, 1896. No. 12.

Original Communications.

MYCOSIS FUNGOIDES, MORE ESPECIALLY THE PRE-FUNGOIDAL STAGE. CLINICAL HISTORY OF TWO CASES.

By PRINCE A. MORROW, M. D.,

Attending Physician to Department of Skin and Venereal Diseases, New York Hospital; Consulting Dermatologist to St. Vincent's Hospital.

THE classical picture of mycosis fungoides as drawn by Alibert, who first described the disease, was that of a "malady which manifested itself upon one or several parts of the body by oval fungous tumors, which arise and develop successively upon the face and upon the thoracic and abdominal regions. These tumors, the tissue of which is analogous to that of mushrooms, after having enlarged, open like putrefied fruits and discharge an ichorus, often puriform and fetid matter." It was not for many years thereafter recognized that these fungous formations represent the advanced or terminal stage of mycosis fungoides, and that the tumor stage is in almost every case preceded for months or years by various forms of eruptive disturbance which constitute an integral part of the disease and enter definitely into its symptomatology.

According to most modern text-book writers, the evolution of mycosis fungoides is characterized by three periods or stages: 1. *An eczema-form stage*, in which the lesions are comparatively superficial and involve only the epidermis and upper layers of the derma. 2. *A lichenoid stage*, in which the skin is affected in its totality and characterized by œdematous infiltration and the formation of lichenoid plaques. 3. *A tumor stage*. Very exceptionally the first two stages may be wanting, and tumors develop *d'emblée*.

The clinical characteristics of these prefungoidal dermatoses have been exhaustively studied by Besnier, under the title of *Les Érythrodermies du mycosis fongoïde.* They exhibit the most diverse characters in their mode of *début;* in their objective features, which embrace a variety of eruptive elements—erythema papules, wheals, vesicles, bullæ, scales, etc.; in their mode of evolution, their duration, and their pathological coincidences. They are often so indeterminate in character as to present the greatest difficulty in diagnosis. According to Besnier, "in its first period the affection can not be divined except by a physician particularly skilled."



FIG. 1.

In the first of the two patients at present under my observation, I have had an opportunity of studying the various phases which the prefungoidal eruption assumed during a period of over two years. It is only recently that the diagnosis originally made has been confirmed by the appearance of characteristic tumors. The photographs of the eruption, which were made at different periods of its development—the first in September, 1894, the second several months later, and the last in October, 1896—are of especial interest because pictorial representations of the pre-fungoidal stage are wanting, possibly

because the nature of the disease is rarely recognized. In my second case, tumor formations were present when the patient first came under my observation. They disappeared entirely with the glandular enlargements which accompanied them, but reappeared coincidently with an erythrodermatitis of almost the entire surface. A feature of especial interest in this case was that the lesions were unilateral, confined to the right upper and lower extremity, for the first three years.

Case I.—Joseph C., aged fifty-four years, presented himself at my clinic at the New York Hospital, September 18, 1894. Family history good; has never had syphilis. Was a soldier in the late civil war and bears the marks of a bullet wound in the left inguinal region. Soon after the war, experienced difficulty in locomotion; entered Bellevue Hospital, and was told that he had locomotor ataxia. These symptoms passed off and he has pursued his occupation of truck driver for twenty-six years. Has had good health with the exception of rheumatism.

The present eruption appeared some six or seven years previously in the form of reddish, slightly scaly blotches, which were scattered over various parts of the body. The redness and scaliness would partially disappear, but never entirely. Some reddened patches always remained. The physician to whom he applied for treatment pronounced the eruption an eczema, and, after failing to cure it, advised him not to have it treated, as his rheumatism might get worse.

Status præsens.—The patient is a stout, ruddy-faced, healthy-looking man. On being stripped, the entire surface of the body from the neck downward to the feet is found to be covered with slightly elevated, reddish patches, variously sized and shaped, for the most part discrete, but confluent in places. The individual patches vary in size from that of a silver dollar to that of the palm. Many of them have coalesced, forming large, irregularly circular and gyrate figures. The patches show marked gradations in color. The intensity of the redness, as well as the infiltration, depends somewhat upon the age of the lesions; when they first come out they are of a scarlatiniform redness, which deepens into a brownish-red, and becomes more somber as the patch gradually fades. Upon pressure the redness disappears almost completely—a faint brownish hue being still perceptible—but reappears instantly upon withdrawal of the pressure. Many of the patches are covered, especially in the center, with thin, dry, easily detached scales. Two or three of the patches between the shoulders and on the back are covered with a crustlike accumulation of gummy

scales which, when removed, show a moist red surface, with small pinhead-sized excrescences which are slightly oozing. These miliary nodules doubtless correspond to the glandular orifices. The patches elsewhere are perfectly dry, with no moisture.

Upon the anterior surface of the left thigh there is a large plaque covering several square inches formed by the coalescence of



FIG. 2.

contiguous patches. The skin is much infiltrated and roughened by small nodular elevations. A circular plaque is observed on the lower portion of the back just above the buttocks. Upon the extremities, both the flexor and extensor surfaces, the patches are harder, more infiltrated, and less scaly.

Over the general surface of the body there is more or less thickening and induration with an exaggeration of the natural lines of the skin. In the photograph from which Fig. 2 is made may be distinctly seen minute rugæ or furrows formed by the folds of the skin, but which are unfortunately not reproduced in the half tone. The patches are quite glabrous; the alopecia does not affect the pubic or axillary region. The sudoral secretion is exaggerated; the patient complains of the excessive sweating. There is no enlargement of the axillary or inguinal glands. The mucous membranes of the mouth and throat are exempt, also the palms and soles.

The subjective sensations of itching are not marked, nor has pruritus been an annoying symptom at any time. Appetite and general health are good.

The patient was ordered Fowler's solution in gradually increasing doses and local applications of Lassar paste. The arsenic was soon discontinued, as it produced an extensive zoster pectoralis on the left side, which was preceded and accompanied by intense burning pain. The neuralgic pains persisted for a long time after the complete involution and cicatrization of the vesicular lesions. It is noteworthy that the mycosic patches upon which the zoster developed were in no way modified in their features of redness and scaliness. Some months later separate hard, nodular elevations appeared along the lines of the zoster distribution.

The patient was now ordered a general nerve tonic in connection with mistura rhei et sodæ, and the Lassar paste locally. Under this treatment there was an improvement in certain minor features of the eruption. The scaliness disappeared and the infiltration was lessened. The lichenoid plaques on the left thigh and buttocks were smoothed down to the level of the surrounding skin.

It would be impossible, without occupying too much space, to enumerate in detail the varying phases which the eruption exhibited during the following eighteen months. Briefly, it may be said that mobility was the most distinctive feature—the elements of the clinical picture were continually changing. While the general aspect remained much the same, there was a constant mutation of the eruptive elements, giving rise to new combinations in the form and arrangement of the patches. Oval or circinate rings would form, a lesion would spring up in the center and gradually enlarge until it fused with the surrounding ring, or contiguous crescentic bands would interlock and form the most curious gyrate figures. Coincident with the development of new lesions many of the older patches would

undergo retrogressive changes and finally fade out, leaving pale pigmentations. The whole course of the disease was marked by periods of activity alternating with periods of repose. At certain times the entire eruption would become paler, as if about to clear up; at the next visit, perhaps, there would be an accentuation of the redness and other inflammatory features. But underneath these alternating changes there could be observed a gradual aggravation of the eruption, marked by an increase in the thickening of the skin and a tendency to tumefaction of certain areas. The chromolithograph does not convey an accurate idea of the thickening of the skin, nor of the elevation of the patches. In September, 1895, there was observed a marked tumefaction of the mammæ, with enlargement of the axillary glands of both sides, which afterward suppurated and discharged. About the same time a soft, brownish-red, cherry-sized lump developed on the flexor surface of the forearm, on the site of a tattoo mark.

As the course of the disease had not been materially modified by the treatment employed, it was decided to experiment with injections of the erysipelas toxines. Accordingly, the patient entered the medical ward of the New York Hospital, November 20th, and remained until December 23, 1895. During this period he was given daily injections of the erysipelas toxines kindly furnished by Dr. Coley, beginning with a dose of two or three minims, which was increased one minim each day while he was in the hospital. It was not until the daily dose had reached twenty-five minims and more that any constitutional reaction was produced. As the result of the last several injections the patient complained of chills, but there was no notable rise of temperature. When the patient left the hospital his general condition was unimproved, and the eruption was rather worse than when he entered.

In January, 1896, the patient secured employment outside the city and did not present himself again until October 21st. It was at once perceived that a marked change for the worse had taken place. He was very pale, feeble, and with other evidences of pronounced cachexia. The changes in the appearance of the eruption on the posterior surface are seen in Fig. 3 (from a photograph taken October 23d). The anterior aspect of the body shows numerous fungating ulcerative lesions on the trunk, thighs, and about the ankles. The entire surface is thickly studded with brownish-red, distinctly elevated patches, most of them circinate in outline, with scarcely a speck of intervening healthy skin. The patches are all scaly and many of them incrusted in the center. Spots of pigmentation of a dark slatish hue are seen here and there. The skin of the face and neck, which had

not before been affected, was now dry, reddened, and the seat of an abundant furfuraceous desquamation.



Fig. 3.

No enlargement of the inguinal glands; palms and soles exempt; nails unaffected; hair of the scalp and eyebrows intact, but complete alopecia of the body. No evidence of leucæmia. Dr. Biggs, pathologist of the New York Hospital, who examined the blood, reports: "No distinct change can be recognized either in the relative number or the structure of red cells and leucocytes, except that the leucocytes are chiefly of the eosinophile variety."

Case II.— Miss X., aged thirty-six years, was referred to me by Dr. Janeway, of this city, May 23, 1895. The patient's personal and

family history good. The first evidences of the disease were manifest in 1890 in the form of intensely itchy, reddish patches, which first appeared on the right arm above the elbow. Later, one of these reddened areas became elevated in the form of a flat tumor, which suppurated and discharged more or less for several months, then dried up and disappeared. Some months later similar reddened patches appeared on anterior surface of right knee, and gradually extended down the anterior surface of leg nearly to the ankle. The patch on the right knee became elevated, moist, and exudative, and discharged, finally becoming covered with a dry, scaly crust. Later, the patches below the knee and others which formed on inner side of the preceding underwent the same evolution. In 1894 numbers of reddened areas appeared on surface of right leg. Some of these became elevated in the form of shotty papules, some as large as marbles, which broke down, forming fungating tumors. Similar patches appeared on the outer aspect of right thigh, on the outer aspect of left buttock, and on both upper extremities. At present there are a number of red elevated tumors on various parts of the body, some of which are broken down and fungating. The glands in the groin were enormously swollen—those of the right inguinal region were so voluminous that they could be readily distinguished through the clothing.

During my absence from the city the patient entered the New York Hospital for abscess of the left thigh. From the hospital records I extract the following notes of the case:

"*June 19th.*—After a walk over a rough field the patient suffered from pain on inner side of right thigh just above the knee whenever movement was made. On June 26th there was observed a slight swelling on inner side of thigh just above the knee, with redness of the overlying skin. The swelling rapidly increased and became softer. There was no pain save on pressure or movement, but at night, if the climb was not comfortably arranged, there would be a burning pain in knee. Patient entered hospital July 6th, and the limb was then in a position of midflexion.

"*July 15th.*—A four-inch longitudinal incision was made on inner side of the thigh, laying the abscess cavity wide open. Counter-opening was made for drainage at postero-internal part of thigh. After the abscess cavity was in process of healing, Volkmann's splint and later Buck's extension apparatus, were applied a couple of hours per day to overcome the flexion of the limb.

"*August 26th.*—Discharged. Leg straight."

Upon my return to the city, September, 1895, the patient again came under my observation vastly improved. There was no trace of the former tumors, except numerous pigmented scars. The glandular enlargements in the groin had also disappeared. There were two raised reddened patches on left leg just above the knee, a small finger-nail-sized reddish disk over right wrist, and a few reddish blotches on left buttock.

With the advent of cold weather there was a rapid extension of the eruption. Patches appeared over both upper and lower extremities, some of which were elevated in the form of rounded or flattened tumors, many of which assumed the most singular shapes. In Fig. 4 are delineated these tumor formations on left thigh. In Fig. 5 are portrayed lesions over right wrist and right knee, showing their tendency to clear in the center and enlarge at the periphery. This was a characteristic feature of all the lesions. The patch on the right wrist has since extended two or three inches above the joint and downward over the dorsum to the roots of the fingers, the central area showing a pigmented cicatrix. Patches also appeared on the back, between the shoulders, and over the right acromion process, all of which are clearing in the center while extending peripherally. About April 1st of the present year a number of erythematous patches appeared on the right breast; about the same time the right nipple began to be tumefied and soon attained the dimensions of a horse-chestnut, with enlargement of an axillary gland on the same side. At the present time the mammary tumor is the size of a small apple, fungating, with numerous dark sloughs extending deep down into the gland substance. The entire right mammary region is the seat of an enormous œdematous infiltration, exceedingly hard to the feel, accompanied with a swelling of the right arm extending down to the tips of the fingers. The glands under this arm are swollen and apparently agglutinated by periglandular infiltration.

The tumors have always been painless until recently, but the patient now complains of an intense burning pain in the right arm, which is paroxysmal in character and more pronounced at night.

The subjective sensation of itching has always been a most distressing feature in this case. Many of the patches are the seat of excoriations caused by the patient's nails during sleep. Examination of the blood, as in the previous case, showed no evidence of leucæmia.

The patient had been taking arsenic before coming under my care, and, as the drug was well borne, this treatment was continued. An ointment of pyrogallol was ordered for the incrusted lesions on the

back of the hand and over the right knee. This was given in two strengths, two per cent and ten per cent respectively. The stronger ointment was occasionally used on the drier, outlying surface, and apparently served to check its rapid extension; the milder ointment



FIG. 4.

was used more continuously on the open surface, which it seemed to dry up. Various ointments—ichthyol and zinc oxide, oleate of bismuth, balsam of Peru, Lassar paste, etc.—were tried in succession, but the pyrogallol seemed to be the most efficient. The open fungous tumors were treated by spraying freely with peroxide of hydrogen, followed by applications of oleostearate of zinc with balsam of Peru. The experiment of injecting arsenic in the immediate neighborhood of the tumors was made with the view of hastening their involution. The tumor formations over the left thigh, shown in Fig. 4, were thus treated, with the effect of causing their almost complete disappearance within three or four weeks. Subsequently hypodermic injec-

tions of arsenic were substituted for the stomachal employment of the drug. These injections were made in the upper arms and thigh and continued daily for some time. At first there appeared to be a decided



Fig 5.

improvement in the general condition of the eruption, but it was of short duration. The thyroid extract was also tried, but was discontinued on account of the nausea and headache induced.

AN UNUSUAL CASE OF LUPUS VULGARIS, LUPUS ANNULARIS.

By GEORGE T. ELLIOT, M. D.,
Professor of Dermatology at the Post-Graduate Medical School of New York, etc.

MRS. F., aged forty-seven years, was seen by me in November, 1891. She was well nourished, her general and functional health was perfect, and she had not had any serious illnesses during her life. There was no history of tuberculosis in her family or antecedents, and nothing suggesting syphilis. She had been in good circumstances, but in the last few years she had suffered from reverses in fortune and was compelled to do the greater part of her household and other work. She was the mother of several children, all of whom were well and healthy.

The cutaneous lesions had appeared two years previously in the form of discrete, brownish spots about the size of the head of a small pin. They were not elevated, painless, did not itch or desquamate, or undergo any particular change for some time. Then slow enlargements in size occurred and, involution taking place in their central portions, ring-shaped lesions resulted, which kept steadily and gradually enlarging. At the same time, progressive and consecutive disappearance of the morbid symptoms ensued in their centers, so that a more or less circular form was persistently retained. There had not been any ulceration or breaking down of the affected tissues during the existence of the disease.

One examinaion, the affection was found to be located on the face alone, the remainder of the body showing no pathological changes whatever. The lesions were fourteen in number. Three were situated on the forehead, three on the right temple, two on the left cheek, one on the right side of the nose near its root and encroaching on the right eyelid, one on the ala of the same side, one on the chin, and one in front of each ear. (See cut.) They varied in size from a three-cent to a five-cent piece. They were for the most part oval or circular, though those near the ears and on the nose were irregular in outline. The

lesion consisted of a white, shiny, smooth and entirely cicatricial central area, which was surrounded and limited by a narrow band —about an eighth to a sixteenth of an inch in breadth—only slightly elevated, a little resistant to the touch, uniform and unbroken, perfectly smooth, of a brownish color, and giving the impression of transulcency. No other symptoms were present, there were no discrete tubercles beyond the peripheries, nor were there any scaling or crusting, or any ulcerated points or areas on or about the patches; nothing in fact existed but these narrow, brownish, translucent rings inclosing the white and cicatricial centers.



Lupus annularis.

In the presence of these peculiar cutaneous manifestations, which had run so slow and chronic a course, and which, while suggestive of various possible processes, yet were not sufficiently definite and indicative of any particular one, no positive diagnosis was made, and, a negative treatment being prescribed, the patient was kept under careful observation.

The progress of the disease was very slow and gradual and shown by a steady increase in the size of the lesions. This took place apparently by a uniform centrifugal advance of the bandlike border and a synchronous cicatricial involution along its inner edge. At any rate, during the whole time the patient has been under observation, the border itself has not varied appreciably in width, the only changes having been an increase in the diameter of the lesions and in the cicatricial areas occupying the central portions. One new lesion, however, developed in 1893, and its mode of growth and transformation into a circinate patch was observed. Beginning as a yellow-brown, pinhead-sized tubercle, it slowly enlarged, became involuted in its central portion, and it then progressed in a ring-form in exactly the manner already described and presumed from the configuration and general aspects of the other patches. After much persuasion, the patient finally allowed a piece to be removed for microscopical examination. A portion of the advancing border was excised from the patch near the right ear. It was hardened in alcohol, mounted in celloidin, and cut with the microtome. Sections were stained with hæmatoxylin and under the microscope they showed the typical evidences of lupus vulgaris. Other sections were then stained

in various ways for tubercle bacilli, and one or two of these were discovered in each section.

The diagnosis of tuberculosis being thus made, the case was designated as lupus vulgaris annularis, and vigorous treatment was instituted. It proving, however, rather severe, the patient disappeared for a year, returning about the end of 1894. Practically the same conditions existed as when she was last seen, except that the rings were larger and in one, *a half-dozen of small typical lupus tubercles* had developed in the central cicatricial area. They were pinhead in size, brown and jellylike, easily penetrated by a small probe or other instrument, and did not tend to break down spontaneously, or to cause any scaling or crusting. Since 1894, the case has been more or less under treatment, but the irregularity in attendance has not enabled the lesions to be removed. Some of the patches have been destroyed, but the majority have not. Of all the remedies used, the stick nitrate of silver has proved to be the best. With it, the tubercular tissue was easily bored out and destroyed, but penetration down to the subcutaneous connective tissue was found necessary before any cessation in the relapsing or further progress of the process was obtained.

Notwithstanding that the clinical symptoms presented by this case proved to be only representative of a not uncommon disease—tubercular lupus—yet there are not a few points of interest in connection with it which may be mentioned and discussed. Particularly interesting are the evolution and development of the patches from the primary tubercle to the annular form of lesion, and the persistent adherence to the circinate type during the years the process slowly progressed in the skin. There is nothing especially unusual in a lupus patch being more or less ring-shaped, and such have been not infrequently recorded. The serpiginous type is also well known and described in all text-books, so that the peculiarity I find in this case is not in that direction, but in the mode of development and the extension of its lesions. I would not have laid much stress upon the patient's description, if I had had that alone to depend upon, inasmuch as such descriptions are necessarily unreliable and would particularly be so in regard to so delicate a point, but I was able myself to observe the origin and course of a patch developing while the woman was under my observation. As mentioned in the history, the primary lesion was a tubercle, pinhead in size—a miliary tubercle—which enlarged slowly and underwent involution in its center. As a result of this, the lesion became transformed into a narrow band, yellow-brown in color,

slightly elevated, etc., inclosing an area which had become cicatricial in texture and appearance. In its further extension, the peripheral band, representing the tubercular or diseased tissue, "rolled" slowly and uniformly onward, being followed *pari passu* by the transformation into a cicatrix of the cutis which had been affected. During the existence and progress of the patch, no other symptoms developed, and it would seem to me, in consequence, that this case of tubercular lupus presented a clinical picture and course somewhat unique.

There are types of the disease which resemble the present one in certain particulars, but none, however, which are exactly similar to it in their mode of development and further course. Lupus miliaris (Unna) or follicularis—adenoid acne (Crocker)—of which I have seen half a dozen cases, besides examining them microscopically and thus substantiating the diagnosis, is characterized by the development primarily of the same small tubercles. These are disseminated in greater or lesser abundance in the affected surface. From my observation, they usually, however, undergo little or no increase in size, but after a variable term of existence disappear, leaving a minute cicatrix; on the other hand, they may enlarge slowly to the size of a small pea, become prominent, soft and jellylike in consistency, and on this account, they have at times suggested to those who did not investigate their histo-pathological construction a colloid degeneration of the skin. In none of the cases I have seen, nor which are reported in the literature of the subject, is there any mention of any further transformation of the primary lesions, and certainly in none was there any progression to the annular type. Lupus maculosus begins also in the same manner and is primarily represented by a miliary brown-yellow tubercle, but its extension is due to the cropping out of new and discrete lesions in the immediately surrounding tissue, and these increasing in number, getting closer together and enlarging, finally become confluent and form a macule of variable size. In its extension, the advancing margin is always constituted by *discrete*, *separate* lesions, while the originally affected area undergoing more or less complete involution, the epidermis covering it becomes wrinkled, shriveled in appearance, desquamating and cracked, and when some extent of the cutaneous surface is implicated in this manner, we have the picture usually designated as lupus exfoliativus. The margin of such a patch may be circinate, or nearly so, but yet it is not uniform in character; it is distinctly constituted by *separate* and *discrete* lesions. In addition, its mode of extension is by the cropping out of the same discrete and distinct tubercles along the

periphery, and these gradually merge into the advancing patch. In no case of exfoliative lupus, have I seen any clinical symptoms similar to those presented by the case under consideration, and yet the majority occurring in this country are of that type. The same particular features of difference can also be invoked in regard to what is usually termed lupus serpiginosus, which is characterized by cicatricial transformation of the surfaces primarily attacked and a gradual "creeping" implication of the adjacent tissues. Here also we find that the mode of extension is by the evolution of fresh, new tubercles along the advancing margin. They then undergo destructive degeneration through ulceration, or, without reaching that point, lead in their involution to such tissue changes as are recognized as cicatricial. The various other varieties of lupus—tuberosus, exulcerans, verrucosus, etc., etc.—do not, naturally, come into differential question with the case which I report in this paper, owing to the manifestly clinical differences which they present, and they are, therefore, left out of consideration.

In July, 1895, a very unusual example of cutaneous tuberculosis was reported in this Journal by Ransom, and it bears some clinical resemblance to the one now under discussion. It was also accompanied by cicatricial involution of the center and an eccentric growth of the morbid process, but its mode of extension was such as occurs in lupus in general—that is, by the development of new discrete tubercles along the border of progression, and not by the uniform marginal advance, which was so marked a feature in this example of the disease.

It is really in its peculiar mode of evolution and progress that I find the uniqueness of this case, as otherwise it can only be regarded as a variety of lupus, and it is this peculiar feature that has led me to report it. Other customary symptoms of the disease were likewise absent, but they are not of special mark. I refer to the want of any epidermic change, such as scaling, shriveling, or peeling of the horny layer, and also to the freedom of the cicatricial areas from tubercular reinfection. As a rule in lupus, and often a valuable diagnostic symptom, new tubercles continually originate in the scar tissue resulting from the disease, which has undergone either spontaneous involution or has been removed by treatment. In this case, however, this occurred in only one of the patches, and then only after an existence of some years.

It can be seen, therefore, that in many features this example of lupus was peculiar, and when its whole clinical aspects were considered, that its diagnosis was not at first sight an easy one. In fact, it

was definitely made only after the microscopical examination and the discovery of the tubercle bacilli in the sections.

When first seen, it was regarded as possibly an example of a superficial form of epithelioma, or one of circinate syphilis, and lupus erythematosus was strongly suggested. Epithelioma was, however, soon discarded, owing to the absence of all evidences of ulcerative tendency, the very moderate density of the elevated border and its brown-yellow color, instead of the dense, pearly, translucent look, so characteristic of the epithelial degeneration. The very slow course, the absence of infiltration, the color, and the entire behavior and appearance of the lesions readily excluded syphilis, while the mode of inception of the lesions, the want of redness, of desquamation, of follicular implication, and the marked cicatricial transformation of the central areas did not after due consideration allow the diagnosis of lupus erythematosus to be entertained.

Another point in the case to which attention may be directed is the age of the patient at the time the disease began, the woman being forty-five years of age when the primary lesions developed. According to the majority of our text-books, lupus rarely originates after puberty. Kaposi even states that when lupus apparently begins in adult life, it is in reality a relapse, the disease having appeared originally in childhood, and then undergone involution and remained quiescent. He claims that it is most common before the age of ten. My experience here does not agree, however, with that view, as it is not unusual for adults to present themselves at my clinics with a fresh and primary lupus—that is, with a first attack. I can recall six such cases in the last twelve months, the youngest of whom was thirty-five years of age when the disease began, and I do not doubt but that the experience of other dermatologists is practically the same as mine. At any rate, an age limit within which lupus can or does originate should not be made fixed and unchangeable, owing to the difficulties this may often place in the way of making the diagnosis, lupus being possibly excluded because the patient was too old and had passed the limit of age when the disease develops. A case in point was seen by me only last spring. The patient was forty-eight years of age, had had a patch of lupus for one year at the root of the nose, and yet the possibility that the clinical symptoms represented that disease had been scouted and thrown aside because of the man's *age*. Still, *all the insignia* of *tubercular lupus* were present, and had it not been for that one fact—*the age*—no hesitation would have existed in making the proper diagnosis.

14 West Thirty-third Street.

Book Reviews.

Die Histopathologie der Hautkrankheiten. Dr. P. G. Unna. Berlin: Verlag von Aug. Hirschwald, 1894.

The Histopathology of the Diseases of the Skin. By P. G. Unna, M. D. Translated into English by Dr. Norman Walker. Edinburgh: W. F. Clay; New York: Macmillan & Co., publishers.

In 1894, Dr. P. G. Unna published his work on the *Histopathologie der Hautkrankheiten,* and in the beginning of 1896, an English translation by Dr. Norman Walker made the book accessible to those not familiar with the language of the original. A work such as Dr. Unna has given to the profession presents enormous difficulties to the reviewer, owing to the newness and originality of the matter which he offers, and the entire, it can be said, reconstructive position which he has taken concerning the histopathology of skin diseases. It certainly deserves to receive more than the perfunctory lines and phrases usually given to publications, whether medical or otherwise, and it should be carefully and critically analyzed, both as to its general scope and its more important and special features. Unfortunately, the exigencies of space and time, as well as other reasons, prevent the reviewer from entering upon a thorough critical analysis of the book in the way in which he would desire. He confesses that he is much to blame for this failure, inasmuch as the original edition has been in his hands since its first appearance, and his only excuse is one, which can not but be apparent to all who study the book—one which will be found in the difficulty of adapting well-digested and fixed conceptions to an entirely new order of things. It is these new points of view which cause incertitude and hesitancy in the mind of the reviewer. He would not wish to praise, unless convinced that he may do so justly; he would not wish to condemn any part or statement, unless it could be done on a warrantable basis. Procrastination thus comes into play and the review is delayed and delayed from the fear of inappreciation of what may be perfectly true and the misunderstanding of a writer's conception.

Dr. Unna states in his preface that in undertaking the work, he found himself confronted with the fact that hitherto the histopathology of cutaneous diseases was only an ornamental addition to text-books, and that the vagueness and indefiniteness of the majority of publications on the subject were such that they were for the most part "antitheses of themselves"—that is, the description of one process could be perfectly well utilized for some other. Unable to undertake the review of the entire subject single-handed, he has, however, done so in part, leaving its amplification and further development to the future. In order to arrive

at any definite conclusions, the author also found it necessary to devise new staining methods, such as would specifically show not only the nuclei of the cells, but also the various kinds of cells, the changes in their protoplasma, and likewise the differences between the normal constituents of the skin and those which were pathologically altered. These staining procedures have been all published in the Monatshefte f. prak. Dermatologie (1895 and 1896), and the reviewer after two years' experience with them can bear testimony to their value and to all the claims made for them by Dr. Unna. The technique is not easy, but, when carried out successfully, amply repays all the trouble and care required.

Unna has likewise coined new expressions to convey his meaning in regard to various pathological conditions, and to explain changes continually occurring and referred to by him. He thus indicates chemotactic attraction of various kinds by serotaxis (attraction of serum), leucotaxis (of leucocytes), fibrinotaxis, and sebotaxis (of sebum).

The work is divided into six sections—Anomalies of Circulation; Inflammation; Progressive Disturbances of Nutrition; Regressive Disturbances of Nutrition; Malformations; Saprophytes and Foreign Bodies.

In the first section are included anæmia, hyperæmia, angioneuroses, such as Quincke's œdema, symptomatic and idiopathic erythanthema, œdema, and hæmorrhage. In this section, I would only call attention to the important fact particularly emphasized by Unna, that œdema is not due to and can not be produced by obstruction or obliteration of the lymphatic channels. Both experimentation and physiological investigation have shown that none of the theories in regard to the closure or defect in the tonicity or in the elasticity of the lymph vessels were tenable causes of œdema, but obliteration or interference with the venous circulation were absolute requisites for its production.

The second section, Inflammation, is the most comprehensive in the book. It is subdivided into (*a*) traumatic, (*b*) neurotic, and (*c*) infectious inflammations. After dealing with traumatic inflammations from mechanical, chemical, and physical causes, Unna includes in this section eruptions produced by iodine and bromine. He regards these as inflammations of the skin due to the circulation in the blood of iodine and bromine, and apparently would make of them a separate class from other drug eruptions. Still, he does not give for this any clear and definite reason, and he certainly leaves the subject very much open to question, giving the impression that it is only these drugs which produce inflammatory lesions when internally administered. The histological features of the subdivisions *b* and *c* of the section on Inflammation, I will not undertake to review any more than those of the subjects already treated. They can be subjected to criticism by any one who will employ Unna's staining methods, which, so far as they have been made use of by me, have shown that his observations with the microscope have been ac-

curate, and that what he states he has seen has been seen by him. It is more particularly, however, his pathological grouping of diseases and his claims in regard to their causation and his conclusions as to their *raison d'être*, which interest me and that I would undertake to call attention to. He thus introduces subdivision *b*, or neurotic inflammations, with the statement that all the dermatoses included here very probably belong in the class of infectious inflammations. He claims that this is unquestionably the case with the neuroleprides and syphilides, erythema nodosum and zoster, and he adds that erythema multiforme (Hebra), the hydroa and herpetic forms have also a right to a similar ætiology. He separates them, nevertheless, from the group of infectious dermatitides, because they are not purely such, but depend upon other influences (nervous) not evident in pure infectious inflammations of the skin. Unna's claims are certainly original in at least one very prominent point—namely, in that he says that these dermatoses most probably belong among the infectious inflammations. In dealing with an ætiological or pathological classification and grouping of diseases, the most important step should undoubtedly be a positive knowledge of their primary inducing causes, while those which are secondary, accidental, or accessory should receive only such consideration as is their due. We regret to say, however, that Unna does not make this evident, inasmuch as he asserts that herpes zoster belongs "most probably to the infectious dermatoses," and yet no specific parasitic agent has so far been demonstrated directly causative of the disease. He mentions Pfeiffer's "amœba," but disposes summarily of it, and speaks of the "presumptive parasite" of zoster, without, however, designating or establishing its existence. We may make the same remarks in regard to the other diseases constituting this group—erythema nodosum, prurigo, herpes simplex, etc.—processes certainly awaiting the discoverer of their parasitic cause, and which even if found, would occupy a peculiar position, absolutely in negation to clinical observation and not explaining the *raison d'être* of the process. How, for instance, to explain a herpes facialis, etc., appearing regularly, *and at no other time*, with a menstrual epoch, if a parasitic agent is the cause of the process. That at times erythema multiforme (Hebra) may be of parasitic origin is unquestionable, but the pathological causation of this disease is so varied that it constitutes a form of eruption almost impossible of ætiological classification. At one time appearing clinically under the influence of drugs, at another of climatic influences, at another as an accompaniment of some infectious process, etc., it certainly seems impossible to regard it as more than a symptomatic manifestation of variable ætiology, and one which, if individual cases are taken, may be most liberally classified.

Much said so far pertains equally to subdivision *c* of Inflammation —"infectious inflammations." Unna distinguishes them according as

they are *local infectious diseases of the skin,* or *general infectious diseases* with *symptomatic* disease of the skin, such as the exanthemata. He further subdivides them according as the germs found (*or their presence assumed*) are in the epidermis or the cutis. The bracketed statement, "their presence assumed," is unfortunately too much the truth for a very large proportion of this class, which contains scabies, pemphigus acutus and chronicus, cheiropompholyx, miliaria rubra et alba, impetigo contagiosa, eczema, psoriasis, pityriasis rubra (Hebra), dermatitis scarlatiniformis, Darier's disease, lichen planus, acne, mycetoma, mycosis fungoides, syphilis, tuberculosis, etc. I have said "unfortunately," for how many of the diseases included here have been proved positively to be "infectious inflammations"? Certainly cheiropompholyx, psoriasis, pityriasis rosea, pityriasis rubra (Hebra), dermatitis scarlatiniformis, pityriasis rubra pilaris, lichen planus, ichthyosis, etc., have not the right scientifically to occupy this position, and while he includes Darier's psorospermosis follicularis among the infectious inflammations, yet Unna denies that the "psorosperm-like bodies" are coccidia, having after careful study concluded that they are only hyaline degenerated epithelial cells. At the same time, he brings forward no new parasite to explain those changes, which have led him to place the disease in the "infectious inflammation" subdivision.

It is in regard to these what may be termed "postulates," that exception may be taken to Unna's pathological statements, and that he lays himself open to criticism. Because in some processes demonstrably parasitic he finds certain histological changes as a result of a germ, he apparently believes without further proof that analogically other processes similarly located in the epidermis or the cutis, and presenting somewhat similar changes, must be the product of similar agents. We can not allow, however, that such is the case, there being too many contradictions to such views, both in the pathological course and in the clinical features of cutaneous disease. It is not possible to group the diseases of the skin to-day according to their pathological causation, this latter being as yet too little established upon a positive basis, and it is not scientifically satisfactory to do so upon a presumptive cause or upon analogical comparison. I would, therefore, say that outside of his pure histological descriptions, it would almost seem as though Unna was writing for the future, not for the present day; was anticipating discoveries to come, not considering himself bound alone by those already made, and he was foreseeing perhaps the time when the actual causation of so much inexplicable to-day would be definitely and positively known. There is so much in Unna's book to be passed upon requiring time to compare every statement made, by a perusal of the literature of the subject and an examination histologically of the diseases treated of, that I would only mention the remaining sections, which deal with Progressive and Regressive Disturbances of Nutrition, Malformations, Saprophytes and

Foreign Bodies. The enumeration of these shows how extensive is the work which he has done, and if I should allow myself to state my appreciation and conception of the work, it would only be in such words of praise as are superfluous at present in view of the general welcome given to it since its first appearance. On every page Unna is present, and notwithstanding the criticisms, which it may deserve, yet it is an embodiment of the indefatigable and suggestive work with which he has astonished dermatology. From the very first, dissatisfied with the placid acceptation of current views which, having been authoritatively enunciated, could not, therefore, be questioned, he, by personal reinvestigation and steady work, showed the filmy basis upon which many accepted theories rested; he did not hesitate to attack most cherished articles of faith, and to earn the title of iconoclast. But what was the result? On the part of many, a renewed study of the questions he brought forward, a stimulus given to work solely undertaken to prove that he was wrong, and through his startling statements, discussion arose anew in regard to subjects which were supposed to be settled, or at any rate were so considered, because a paramount authority had so declared. Instead of individual reinvestigation of dermatoses being undertaken, the fetish of a name representing some one school was invoked as sufficient proof of a theory, or was made use of against every innovator in dermatology, and it was Unna, who, casting aside the absolutism of such authority, set to work to give a new impulse to the study of dermatology. That he has not failed is at least shown in the frantic efforts of his opponents to place him in the wrong, to disprove his observations, doctrines, methods, and his every point of view, and if only the amount of work in that direction is considered, we owe him a debt of gratitude. Scientific dermatology would be much the loser if it had not been for the efforts of these opponents of Unna's doctrines, and he can not but feel the satisfaction of having inspired so much good work. It is only mediocrity which passes current uncriticised, and certainly from the standpoint of criticism, Unna's work can not be considered mediocre. My conception of the author's work, especially in regard to his Histopathologie, can not be misunderstood from what has just been said. It is open to criticism, it is true, but it is one of the most powerful stimuli to an *honest* student of the science of dermatology which has come into my hands. It deals with the entire subject in a broad, comprehensive manner; it states frankly the known and presumed causes of a process; it suggests innumerable questions for solution, and it can not but act as a stimulus to renewed study and investigation of those many simple and complex cutaneous manifestations met with on every hand.

The book should be in the hands of every dermatologist, who is thoroughly and really imbued with the spirit of progress and who seeks the improvement of the branch of science to which he is devoting himself. This is within the reach of all those to whom the German language is

unfamiliar, by the admirable translation made by Dr. Norman Walker. The translation is further enriched by numerous illustrations in the text, and they serve to increase the interest of the reader. In fact, they are so well done that we regret that every article is not so illustrated. Great praise is due Dr. Walker for his energy and care in the translation and certainly much also to the publishers, who have evidently in the publication of the superb volume spared nothing to make it acceptable and desirable to all. George T. Elliot.

Society Transactions.

AMERICAN DERMATOLOGICAL ASSOCIATION.

Twentieth Annual Meeting, held at Hot Springs, Virginia, September 8, 9, and 10, 1896.

A. R. Robinson, M. D., of New York, *President.*

(*Concluded from page 463.*)

Some Glycosuric Dermatoses was the title of a paper presented by Dr C. W. Allen, of New York.

If there were sufficient marked characteristics to distinguish the diabetic eruptions from those of similar nature but of distinct non-diabetic causation, we might be warranted in making of them a class apart, and we could then have our diabetides just as we have our syphilides, leprides, etc. The writer's objection to this is that many of the cutaneous manifestations due to the presence of sugar in the system occur in glycosuria, which is not to be confounded with the disease diabetes. Instances of dermatoses disappearing with a transient glycosuria were quoted, and the possibility of glycosuria following furuncular and suppurative processes was referred to. Both symptoms might depend upon a common cause. An instance of true diabetes following carbuncle, or at least not being detected until some time afterward, was mentioned. A series of eruptions which the writer had not found mentioned in the literature of *dermatoses diabeticæ* were recorded. The first of these was an eruption involving the scalp, extensor surfaces of the arms, backs of the hands, thighs, legs, and backs of the feet. It consisted of rounded lesions, either with a "scooped-out" center or covered with crusts which had a central depression somewhat like those seen in acne varioliformis of Hebra. Other lesions had the appearance

of superficial erosions, rather oblong than rounded, presenting a glazed or varnished-like surface. They were irritable rather than itchy, and many had been aggravated by picking at the crusts. The picture as a whole was more suggestive of acne cachecticorum than of the acne necrotica above mentioned, which is usually limited to the forehead and a few hairy regions, and has smaller lesions with a crust mortised in at the summit. The lesions, too, were much more obstinate than those of acne varioliformis.

Another form of lesions which occurred in the presence of a high percentage of sugar was described as *acute multiple gangrene* of the skin, of very superficial nature, the ulcerations extending at the periphery until some were of quarter-dollar size; the base grayish-yellow, with the red points of papillæ showing through. The patient was confined to bed for about a fortnight.

Pigmented areas remained where many of the lesions had existed, and some of them became covered with a strong growth of hair. Bronzing of the skin as a condition *per se* was spoken of, and the fact that Mossé had demonstrated pigmentations on mucous membranes in diabetics, contrary to the generally accepted view. Erysipelas in diabetics was then taken up and an instance of death related in which the patient was syphilitic, very obese, weighing three hundred and fifty pounds, and affected with extensive sloughing and undermining of the skin about the trunk. Erythema, dermatitis, and eczema about the genitals, possibly leading to gangrene, received passing notice, and xanthoma diabeticorum, which some observers maintain is not a xanthoma at all, but more properly called lichen diabeticus, was touched upon. The latter was not thought to bear a close clinical relationship to the xanthoma usually seen about the eyelids. The peculiar vulnerability of the skin in diabetics was referred to, and the slight tendency to heal which lesions from injury or disease manifest. The skin is in a constant state of receptivity for pus-producing organisms, all of which may be explained by the presence of sugar in the tissues.

DR. WHITE said that the report presented was extremely interesting, but the author had failed to mention that form of dermatosis which he regarded as the most characteristic one. The reader had alluded to a furuncular diathesis, but this could be easily explained without resort to the theory of a diathesis. The skin in the diabetic state furnishes a good nidus for the development of the furunculous coccus, irrespective of the existence of any so-called diathesis. All were familiar with a very acute eczema of the genital region of stout, diabetic women. He had on several occasions noticed a much more diffused and an intensely acute form of erythematous eczema or dermatitis, which possessed a very evanescent character, reminding one somewhat of the erythema sometimes associated with the œdema of the lower extremities. This form of acute eczema is so intense as to indicate some unusual condition in the

patient. Examination of the urine had established the presence of diabetes, and he had come to look upon this dermatitis as characteristic of diabetes.

Dr. Duhring expressed his gratification at the information conveyed to the dermatologists by the paper. In his own particular field of observation he had not met with glycosuria so frequently in connection with furuncle as appeared to be the case with most other observers.

Dr. Morrow said that it had always been a question with him as to the mode of production of these eruptive troubles so commonly found in diabetics. They had been explained on the assumption that they were due to the local contact of saccharine urine and the products of its decomposition favoring the development of certain fungi and parasitic growths. He doubted if this were a sufficient explanation. Dr. White had mentioned cases of eruptive trouble situated on parts quite remote from the genital region, and where there was no possibility of contact with the saccharine urine, and other observers had reported similar instances. It was known that the presence of sugar in the blood modifies its chemical properties and its power of maintaining the nutrition of the tissues. For example, there were many disorders connected with the follicular apparatus of the skin in diabetics, and it had been asserted that the sugar was excreted by the cutaneous glands, and that in the process of excretion these structures had been irritated. He thought, however, we could explain many of these eruptions, just as we did many drug eruptions, by the presence of a foreign substance circulating in the blood. There was an immense number of clinical observations bearing upon this point. Almost every form of eruptive disease had been encountered in connection with diabetes.

Dr. White asked if Dr. Dyer had any experience with the sugar-workers in Louisiana as to the effect of such employment upon the skin. In the days when the old brown sugar was found in the grocery stores, an inflammation of the hand, called "grocer's itch," was quite common, and was supposed to be due to the handling of the brown sugar.

Dr. Duhring said that some observers held the view that "grocer's itch" was due to the "sugar mite." He possessed a drawing of such a mite, but had not investigated the subject.

Dr. Dyer said that he had seen quite a number of examples of simple trade eczemas in sugar-workers, due to the irritation caused by the sugar water.

Dr. White said that when he was working in the chemical laboratory, thirty or more years ago, there were two specimens of brown sugar containing these "sugar mites" in enormous numbers. He experimented with these, smearing his skin with the mites, yet they produced no irritation whatever.

Dr. Winfield said that he had seen many of the workers in Havemeyer's large sugar refinery, and he recalled a number of cases in which

there was a peculiar eruption—like a parasitic eczema. When these men kept their hands out of the sugar water, the eruption of the skin would disappear.

DR. ALLEN, in closing the discussion, said that he had touched upon eczema of the genitals in his paper, but had not taken the society's time in reading it. He did not mean to say that he frequently found sugar in cases of furunculosis, but that he made it a point in such cases always to examine for it. He believed with Dr. Morrow that it was the local contact of the urine which set up certain irritations, but that others were due to elimination of sugar by the cutaneous glands. He referred to experiments proving this point.

DR. MORROW said regarding the frequent occurrence of furunculosis and carbuncles in connection with glycosuria, that it had been estimated by a very careful authority that fully thirty-four per cent of all cases of furuncles and carbuncles were caused by sugar in the urine. In 1840 the statement had been made by Prout that all such cases were associated with glycosuria.

Xanthoma Diabeticorum was the title of a paper next read by DR. ROBINSON, of New York, in the course of which he described the case of a woman, who had never been jaundiced herself and had never had a relative thus affected. During the past ten years, however, she had suffered from gallstones. The eruption first showed itself in 1891, especially upon the anterior surfaces of the forearms and about the elbows, with a few scattered spots upon the knees. With the exception of those about the elbows, they all disappeared. In the present attack about one hundred and fifty lesions made their appearance upon the right arm, and about the same number upon the left; but in the latter there were none over the fingers or joints. About fifty lesions are present upon each leg, from the calf to the middle-thigh region. The face and eyelids are free. The size ranges from that of a pin's point to a pin's head. The color is yellowish, with a tinge of red. On pressure the former is intensified. The urine showed no sugar, but the report of the examiner was that it appeared "glycosuric." It contained twenty per cent by bulk of albumin and a few granular casts. A photograph of the patient was shown.

The interesting features of the case were the absence of sugar in a person who had the physical appearances of a diabetic, the presence of a parenchymatous nephritis, the desquamative hidradenitis, and the condition of the gall bladder.

DR. DUHRING said that he was interested in the report of this case because he had observed a similar one recently, as regards the lesions. The diagnosis was difficult because the lesions were particularly small. A small quantity of sugar only was found in the urine. Under antidiabetic treatment the lesions disappeared, but recurred on a return to ordinary diet. The lesions gave rise to no special inconvenience.

Dr. Morrow said he believed that the constant presence of sugar was not universal in cases that had been reported as xanthoma diabeticorum. He had looked up the literature of the subject, and had found that one case in particular, that of Besnier, had been observed for several months, and had been pronounced by all the physicians who had seen it to be an undoubted case of xanthoma.

In none of the examinations of the urine was sugar found. In another case the sugar was supposed at first to be absent, but it was found that it was present only for a time after the morning meal. This had led to the suggestion that there might be an intermittent glycosuria, which was probably present in all these cases.

Dr. Allen said he would expect that if the urine were persistently examined, sugar would be found in the case reported. He had occasionally met with cases of intermittent glycosuria. He had seen a few cases of the usual form of xanthoma diabeticorum, not in his own practice but in that of others.

At one time he had had in New York city an example of very intense jaundice associated with enormous patches of xanthelasma. He was able to obtain post mortem only the gall bladder and a piece of the liver. The surface of the liver was seen to be pathological, and made him suspect that xanthoma was present in its substance, and the organ was greatly enlarged. The specimens were sent to a microscopist for examination, but they had been mislaid by him, and hence no report had been made.

Dr. Robinson, in closing, said that it was remarkable that this condition should be so rare and diabetes so comparatively frequent. At the time of the report of his first case it was the tenth on record, and up to the present time only twenty-nine had been recorded. This patient had a parenchymatous nephritis and a desquamation of the epithelium in the upper half of the coil duct, tending to show a close physiological connection between the kidneys and the sweat glands. This connection he had noticed in other conditions.

Dr. Morrow said that it was a well-known fact that a person suffering from diabetes frequently gets up an interstitial nephritis, and then the sugar might definitely disappear. He had never known, however, that an interstitial nephritis might precede the glycosuric condition, and he would like to know the experience of others.

Dr. Robinson said that he had never found sugar in connection with parenchymatous nephritis, but knew no reason why it might not occur.

A Case of Hypertrophic Rosacea (Pachydermatosis) resembling Tubercular Leprosy, cured with Thyroid Extract.—By Dr. Isadore Dyer, of New Orleans.

On January 21, 1896, the patient applied for treatment of everted lids at the eye department of the Eye, Ear, Nose, and Throat Hospital

in New Orleans. He was referred to Dr. Dyer as a suspected case of leprosy.

The patient was an Alsatian, aged sixty years. He had lived in the United States fifteen years, most of the time in Louisiana. Farmer by occupation. Early history obscure, as he was not inconvenienced by the cosmetic presence of the eruption. The nodose appearance of the skin, the ectropion, the extent of the eruption on the face suggested leprosy as a diagnosis. The limitation of the eruption to the face and to the dorsi of the hands were the first points in the exclusion. Patient had always been healthy and was in excellent general physical condition at time of examination. The backs of hands presented a thickened, keratosiform condition, with scaling, but with no primary lesions. The skin of the face was much thickened, arranged in rugæ, running for the most part in parallel lines, a pencil's breadth apart. These crossed at points an inch, half an inch, and less apart, giving a tessellated appearance to the eruption. There was extensive scaling, with excoriations here and there, showing that itching was almost constant. The color of the skin was a dull red, but in nowise brownish, bronzed, or dusky, as is found in leprosy. There were no tubercles at any part of the eruption. Telangiectasis was nowhere present.

The marked infiltration, the thickening and elevation of the skin in regular nodose lines, with persistent scaling, suggested the name of pachydermatosis for the condition, which was adopted. Salicylate of sodium was administered internally with no local treatment.

February 4th.—No change in condition. Iodide of potassium was substituted.

11th.—Scaling and itching increased. Ointment of olive oil and diachylon was prescribed.

29th.—Condition unchanged. Resorcin, half a drachm; liquid tar ointment, two drachms; olive oil, an ounce and a half; diachylon ointment, two drachms, was ordered applied. The iodide was continued.

March 7th.—The condition was still uninfluenced by treatment.

The Atlas of the St. Louis Hospital Museum in Paris had just come at this time, and under the observation of the writer a similar case was pictured under the diagnosis of hypertrophic rosacea. The early life of the patient under weather exposure and the usual history of a progressive rosacea, especially in neglected cases, forced him to the conclusion that his case was identical with the one there illustrated. The pachydermatosis was so marked, however, that it must necessarily be considered a part of the condition, especially when the implication of the hands was considered. The external application was continued, and five grains of thyroid extract were prescribed to be taken three times a day.

21st.—No evidence of improvement. Thyroid continued at same dose. Locally, resorcin, twenty grains; rose water, four drachms; lanolin, enough to make two ounces, was ordered.

April 11th.—Less inflammation; less scaling. Treatment continued.

25th.—Material improvement. Skin paler and softer.

May 24th.—Skin of face and backs of hands soft and normal to the touch. The rugæ had in large part undergone resolution. Everywhere the skin, formerly tense in its infiltration, was compressible, though not œdematous. The morbid color had entirely disappeared, the softened skin being a normal flesh color, slightly pink.

The suggestion of the diagnosis made had been entirely obliterated. The patient's general condition was excellent, and he had in no way suffered from the medication. The ectropion had almost disappeared, but the lids had so softened as to be no longer uncomfortable.

Dr. White said that the report did not recall to his mind any form of pachydermia that he had seen. After looking at the photographs and hearing the report, he would be disposed to ask if there were any evidence of myxœdema in the case.

Dr. Dyer replied in the negative.

Dr. Duhring said that he failed to comprehend why the diagnosis of hypertrophic rosacea was entertained. On the other hand, the term pachydermatosis seemed to him quite appropriate.

Dr. Jackson said that he also failed to see why the term rosacea was applicable to the case. It seemed to him that it was rather one of mild myxœdema.

Dr. Fordyce also thought the case very closely resembled one of mild myxœdema.

Dr. Dyer, in closing, said that he had changed the diagnosis from pachydermatosis to hypertrophic rosacea after seeing a plate recently published in the Pictorial Atlas of the St. Louis Hospital Museum in Paris, presenting an almost identical appearance. His case presented no suggestion of cellular œdema. As far as could be ascertained, the hypertrophy had developed gradually, and the affection had lasted about nineteen years. He thought there was enough pachydermatosis present, however, to justify the retention of this term. The thyroid gland showed no enlargement, and the patient enjoyed excellent general health. His only reason for applying for treatment was the condition of the eyes.

A New Comedo Extractor.—Dr. C. W. Allen, of New York, exhibited a new comedo-extracting forceps which he had devised, and demonstrated its action upon a subject with large comedones. This instrument was quick in action, and allowed of lateral compression being made upon the skin. A three-edged lance was attached for opening pustules and incising the sebaceous ducts, etc., so that with one instrument alone in the hand acne cases could be treated.

The Relation of Dermatitis Herpetiformis to Erythema Multiforme and to Pemphigus.—Dr. Louis A. Duhring discussed this subject, stating that some cases of dermatitis herpetiformis possess similar features to those characteristic of erythema multiforme, especially to the ery-

thematous and bullous varieties of that disease. In dermatitis herpetiformis, however, the cutaneous manifestations are in most instances more intense, more persistent, and more chronic. The formation of pustules, especially miliary and acuminate, so common in dermatitis herpetiformis, is a symptom that is lacking in erythema multiforme.

The other well-known disease to which dermatitis herpetiformis bullosa bears likeness is pemphigus, but from which it differs in important particulars. As characteristic of dermatitis herpetiformis may be mentioned irregularity or even capriciousness in the production of the lesions; polymorphism, more notable even than in erythema multiforme or eczema; the tendency to relapses and to recurrences; the irregularity in the evolution of the lesions, especially a tendency to radical and abrupt changes in the kind of lesions; and finally the presence of herpetiformity, without which dermatitis herpetiformis can not exist. All these features are peculiar to the disease and are wanting in pemphigus.

The conclusions reached were (1) that dermatitis herpetiformis was in most instances a disease with well-defined, tolerably constant clinical features; (2) that it was more closely allied to erythema multiforme than to any other generally recognized disease; (3) that the bullous variety resembled pemphigus, but differed from it in the peculiar inflammatory and herpetiform character of the lesions, as well as in the tendency to polymorphism, the irregular and peculiar evolution of the lesions, and in its cause.

DR. FORDYCE said that he thought all recognized the existence in this country of dermatitis herpetiformis. Cases of recurring eruptions of multiform type, and frequently leaving pigmentation behind, we had been unable to diagnosticate and classify until we recognized this separate and distinct type of disease. Lately, he had seen a case of multiform eruption with bullæ, and with itching and pigmentation. In this case there was also a chronic nephritis, and this possibly was the cause of the eruption—the retention in the system of certain chemical products which cause by their irritant action these skin lesions.

DR. JACKSON expressed his pleasure at hearing this paper. He was thoroughly in accord with Dr. Duhring's previous description of this interesting disease. He was sure that many cases which had been reported as pemphigus were rather dermatitis herpetiformis.

DR. WHITE said that he differed with Dr. Duhring in the essential part of his conclusions. He thought that the term multiformis was a far better one for this disease than herpetiformis, (1) by reason of the great multiformity of its lesions; and (2) the variations assumed by the disease in the different recurrent attacks in the same individual. The term multiformis was, therefore, applicable. On the other hand, the term herpetic seemed to him a misnomer, because the type of the lesions was only exceptionally that of the lesion characterizing herpes. He had never seen a case of dermatitis herpetiformis in which he thought he

would mistake any area of the skin as being an expression of the lesions which characterize herpes. Nor did he think that the disease in its location especially affected the course of nerve tracts, as in well-known forms of herpes. The unlimited duration of many of its lesions was wholly unlike the self-limited duration of the lesions of herpes. With regard to the term herpetiformity, he said that he saw no more reason for calling this a neurotic disease than any other dermatosis of an acute character, accompanied by marked pruritus. He saw no more reason for calling this an expression of herpetiformity than for applying the same term to acute eczema. If we were going to regard all cases of acute itching, inflammatory processes on the skin as necessarily herpetiformity, then, of course, this would come under such a category. The simile used by the reader of the paper, that it was an evidence of the neurotic skin, or of neuritism, did not seem to apply properly to alopecia areata. In ninety-nine cases out of one hundred, he saw no demonstrated reason for considering alopecia areata a neuritic condition. Another reason for considering dermatitis herpetiformis misleading was that many of these cases showed no suggestion even of herpes. We had examples of pure urticarial conditions of the skin lasting for a long time, and later on terminating in other manifestations of this disease, and proving it not to be chronic urticaria. He agreed entirely with the reader in regarding the disease apart, but he could not quite agree with him in saying that individual cases could be so easily distinguished from pemphigus at any one moment. Of course, in observing any case over any considerable time, we should be always able to make the diagnosis.

Dr. Allen said he had been much interested in the paper, for it cleared up one or two points about which there had been doubt. Certain quotations had been made regarding the reader's beliefs which had made a knowledge of his views not altogether clear. He thought the writer deserved great credit for establishing this disease, which is a disease by itself, differing from pemphigus and other bullous and vesicular diseases. Personally, he had always believed, and had occasionally expressed in writing the belief, that multiformis was a better term than herpetiformis. It should be remembered that in the beginning of this disease three or four different kinds of eruption may appear together, and yet none of them closely resembling any of the ordinary forms of herpes or zoster. The cases that he had seen did not especially suggest to him the ordinary herpes. He knew of no definite reason for speaking of the eruptions following certain courses of nerves any more than of following any special course of lymphatics or blood-vessels. There seemed to be no proof that the nerves had anything to do with the special course of the eruption. He hoped to be able to present a case resembling somewhat the disease described by Dr. Duhring, but in his patient there appeared to be a distinct infection. Some of the symptoms would be classified as neurotic. In his opinion, in the great majority

of cases there was more evidence to support the belief that alopecia areata is a contagious or an infectious disease, rather than one depending upon changes in the central or peripheral nervous system primarily. He believed the time would come when it would be demonstrated that there are micro-organisms at work in alopecia and that the disease is transmissible.

The PRESIDENT said if the term dermatitis was to be used at all, he was strongly in favor of using it in the manner employed by Dr. Duhring. He was of the opinion that dermatitis multiformis was a term entirely too indefinite, and hence he preferred the word herpetiformis to multiformis. He was surprised that Dr. Duhring should use as premises in an argument the neurotic nature of alopecia areata, as if the nervous-origin theory were a generally accepted view, which it is not. This term alopecia areata was another example of error in the choosing of a symptom for the name of a disease, He was of the opinion that the disease under discussion was most certainly an infectious one. Personally, he looked upon it as a toxic disease, manifesting itself through the blood-vessels or the nervous system.

DR. DUHRING, in closing the discussion, said that it was his belief that the causes of this disease were varied. Dr. Fordyce had referred to a case in which there was a nephritis, and Dr. Robinson had spoken of cases which, in his opinion, were infectious. His own clinical observations of these cases would go to show that the causes are varied, although he was not prepared to say just what these causes are. The name of the disease was, of course, of importance. He thought the term herpetiformis was more exact and definite than multiformis. Herpetiformity was an essential of the disease, although by this term he did not only mean a resemblance to herpes simplex or to herpes zoster. The original idea and meaning of herpes was "a creeping disease," and probably the first application of the term herpes was to common ringworm, which, as is well known, is at times characterized by vesicles. He used the term herpetiform rather than herpetic, because he thought it expressed this broader meaning better. The term multiformis was very vague; it might, as Dr. Robinson said, be applied to an eczema. For these reasons, if there were no herpetiformity observed after due observation of the case, he would exclude the diagnosis of dermatitis herpetiformis. Dr. White, Dr. Duhring further remarked, thought the disease was rarely, if ever, herpetic. He (Dr. Duhring) did not make use of the term "herpetism." Dr. White had also said that herpetiformis might just as well be applied to an eczema. With this Dr. Duhring could not agree. He was willing to admit a relationship in the symptoms, and probably also in the ætiology, to pemphigus, but he thought that the differential diagnosis could be correctly made after proper observation. He had not said that the disease followed the course of nerve trunks; he had said that the cutaneous nerves were implicated—a different statement. It seemed

to be well established now, that in herpes zoster the cutaneous lesions probably take their origin in most cases from the central ganglia. He had never seen any evidence of dermatitis herpetiformis following the course of certain nerves, but certainly the cutaneous nerves were implicated, and gave rise to the peculiar evidences described under the term "herpetiform."

Dr. Allen said that he had in writing referred to the affection as "Duhring's disease," and he hoped this nomenclature would be generally adopted by dermatologists.

Impetigo Contagiosa Universalis was the title of a paper by Dr. C. W Allen, of New York, in which a case was described and photographs shown of a little girl who began to have bullæ form about a vaccination mark, and spread from the arm and shoulder to all regions of the body. She was first seen by the writer four months after the peculiar affection began, and it was only some five months later that the process came to an end.

Some of the bullæ were large, and, as many deeply pigmented spots were left behind, the whole process resembled pemphigus. The writer believes it the same condition which has been described as pemphigus contagiosus, epidemic pemphigus, etc.

The origin in vaccination, the presence of lesions upon the face, clinically identical with those seen in some cases of impetigo, the benign course, and failure of internal remedies, were the chief factors upon which the diagnosis was based.

Painful denuded areas were left by the rupture of the larger bullæ. New crops came out in the neighborhood of areas previously affected, and separate bullæ would occur upon pigment spots, the site of former lesions. Glandular swellings were pronounced, especially in the groin; the fingers, toes, palms, and soles remained free.

The treatment under which the patient finally recovered consisted in applications of ichthyol in collodion painted on so as to form an occlusive dressing. Bichloride bandaging also seemed to act well for a time.

Dr. Dyer said that he had been very much interested in the report of the case, for it suggested to him that he might have made a mistake in diagnosticating a series of similar cases. In New Orleans there had been a recent outbreak of smallpox, and following the necessarily extensive vaccination there had been numerous vaccination eruptions. The first eruption of this kind that had come to his notice was in a little child in whom he found what he supposed to be true dermatitis herpetiformis. The photographs just exhibited are, however, identical with those of his own case as regards the arrangement of the lesion. The lesions were for the most part bullous. A few days later, he found the spots had become hæmorrhagic. After several days in the hospital the child became almost comatose, and the urine was found to contain a large quantity of albumin.

The case had been under observation for two years, and there had been recurrences of a true herpetiform type of eruption. He had seen three other cases of this kind, in only one of which was there no albumin in the urine. From the paper read this morning by Dr. Duhring he was inclined to think that perhaps after all the correct diagnosis was dermatitis herpetiformis.

DR. WHITE asked if there were any similar cases in the patient's immediate surroundings.

DR. ALLEN said that in the same part of the city there was another case, and within a few blocks he had seen a number of cases of impetigo contagiosa of the face and arms.

DR. WHITE said that cases of widely distributed staphylococcia present features quite different from those described in the paper, and hence it was unfortunate that in the case reported there had been no examination made to establish the presence of the staphylococcus.

DR. DUHRING said that he believed the point had not been brought out as to whether there was any true herpetiform element present, nor had any proof of contagion been adduced, or of the existence of microorganisms. The absence of a history of contagion certainly militated against the diagnosis of impetigo contagiosa universalis.. If he had been asked to look at the photographs without a detailed knowledge of the case, he would have been inclined to make the diagnosis between pemphigus and dermatitis herpetiformis. Regarding the existence of the latter disease in young persons, he would say that in his experience the disease had been very much milder than in adults—sometimes so mild as to lead one to doubt the diagnosis. In children affected with this disease there appeared to be a special tendency to the formation of papules and papulo-vesicles. From the report of the case he would hesitate to make the differential diagnosis between the two diseases mentioned, but he would be strongly inclined to exclude impetigo contagiosa.

DR. ALLEN, in closing the discussion, said that it was his belief that there existed vesicular and bullous forms of impetigo contagiosa, and it was quite possible that there was also a hæmorrhagic form, although he had never seen it. The mere fact of vaccination being the immediate ætiological factor was so much like the clinical history of impetigo contagiosa that it became the first point in the diagnosis. Another point was the fact that lesions about the chin were distinctly those of the ordinary form of impetigo contagiosa, as usually observed. There was nothing in the distribution which he could describe as "herpetiform." There was a herpetiform feature to the spreading of the bulla —that is, in the sense that the epidermis became undermined, and the bullæ extended by raising up the horny layer around the original lesion. The element of contagion, it was true, was wanting, but if we admit that the disease might be accidentally inoculated with the vaccination, or that

saprophytes might be introduced from the unclean surface of the skin, and that new portions of the surface could be inoculated by scratching; this, to his mind, was equivalent to that communication of the disease from one person to another. The clinical features of the lesions made it almost certain that staphylococci were present, although the notes of the microscopical examination and cultures, if any were made, are not available, and do not make part of the report. He asked Dr. Duhring if he regarded vaccination as an important ætiological factor in dermatitis herpetiformis.

Dr. Duhring replied in the negative.

Eruption from the Local Use of Iodoform (with Colored Drawings).—Dr. Fordyce, of New York, showed two water-color sketches of an unusual form of iodoform dermatitis occurring in a man with pulmonary tuberculosis and following the application of the drug to a contused finger. It consisted of large patches of grouped tubercles, papules, papulo-vesicles, pustules, and elevated erythematous spots, involving the hands, forearms, neck, and face. A colored drawing of an eruption resulting from the internal use of iodide of potassium was shown, in which almost identical regions were involved.

Exhibition of Colored Drawings, Photographs, and Photomicrographs.—Dr. Fordyce then exhibited several colored drawings illustrating an unusual form of granuloma, occurring on the anterior surface of the leg, the popliteal spaces, the penis, the scrotum, and over the sacrum.

He also showed colored drawings of cases of symmetrical keratosis of the cheeks, tinea barbæ, psoriasis of the palms, atrophy of the skin following involution of molluscum fibrosum tumors, congenital nævus of the eyelids, epithelioma of the scalp with papillary outgrowth, epithelioma of the auricle, mycosis fungoides in the stage of tumor development, lupus erythematosus of the cheek after frostbite, and a case of erythema multiforme of the arms, of toxic origin. Photographs of pityriasis rubra (of Hebra), ichthyosis, nævus papillaris, molluscum fibrosum, and of complete alopecia resulting from early syphilis were shown, together with a number of photomicrographs of pathological conditions.

Dr. White said that in an extensive series of cases of iodoform poisoning under his observation he had never noted the appearances presented in the photographs exhibited by Dr. Fordyce.

Dr. Duhring said that he had examined these photographs with the greatest pleasure, and would compliment Dr. Fordyce particularly on the great skill displayed in this photographic work.

Dr. Morrow said that he had seen eruptions of a distinctly bullous character from the topical use of iodoform. He had also seen eruptions distributed on the face and neck from the application of iodoform to the finger. It was probably due to the local transference from the point of the finger when the dressings were removed, rather than from any systemic effect of the iodoform consecutive to absorption.

DR. ALLEN said that he had at a previous session, in discussing Dr. White's paper, mentioned a case of iodoform dermatitis spreading on the skin surface, and not limited to a single region of the body, when the iodoform had been applied to a crushed finger, and he had stated that it was one of a number of such instances that he had seen so that he had come to believe that there was a distinct connection between crushing injuries of the finger and iodoform poisoning. He had observed in one case of iodoform poisoning, referred to him by Dr. McGuire during the past winter, an appearance very similar to that presented in the photograph. In other cases he had seen eruptions in which the location had forced him to the conclusion that they were the result of absorption of the iodoform into the system.

DR. FORDYCE, in closing, said that the fact that the man had tuberculosis probably accounted for the severity of the eruption. He had on a former occasion presented to the New York Dermatological Society a case in which, after the application of iodoform to a crushed finger, a bullous eruption had appeared on the face and arms, the scrotum and legs.

Exhibition of Photographs.—DR. MORROW showed photographs illustrating the pre-mycosis stage of mycosis fungoides.

Dr. Morrow said that he had had this case under observation for two years, and there had been marked changes in the eruption during this time. It was never the same for any continuous period. The erythematous patches would enlarge by peripheric extension, and would then disappear, only to be followed by new patches. On the outer aspect of the thighs there was a continuous sheet of nodular eruptive elements. There were no characteristic tumors of mycosis fungoides. The patient was subjected to treatment with erysipelas toxines as an experiment, but the eruption was distinctly aggravated by this treatment.

Photographs were also shown of mycosis fungoides in a more advanced stage, with deep pigmented cicatrices. This patient's body, from the middle of the waist downward, was covered with large tumors. At one time, phlegmonous inflammation developed on the right thigh. Singularly enough, after the drainage of this cavity the tumors disappeared. They again developed subsequently. Some of the tumors disappeared under daily local injections of five drops of a solution of arsenic.

Still other photographs were exhibited of a case considered to be in the pre-mycosic stage of mycosis fungoides.

Photographs of a case of syphilitic eruption closely resembling lupus were shown. Treatment proved the case to be of a syphilitic nature.

The last photographs were from an old man presenting a cutaneous affection of an undetermined nature. On the back of the shoulders were growths resembling keloid, except that they were dark blue. There was a fimbriated growth in the axilla, attached by a very narrow

pedicle. He also had a tumor removed from the right groin, connected with which was a distinct chain of enlarged abdominal glands supposed to be of a sarcomatous nature.

Dr. White said that a case which had attracted wide attention among dermatologists in Paris—"the red man"—was believed by some to represent the prodromal stage of mycosis fungoides. After remaining eighteen months in this condition there was a rapid evolution of the most characteristic forms of mycosis fungoides, and death speedily ensued.

Dr. Duhring said that he was inclined to regard the diagnosis of mycosis fungoides as correct in both the cases presented. Within the last two years he had seen two cases in which there was a sort of brownish-yellow salmon color to the patches. This coloration he considered to be rather characteristic.

Dr. White said he had recently had under observation a case of the affection presenting large patches of a brown color. The case had been sent to a hospital with the erroneous diagnosis of leprosy.

Photographs presented by Dr. A. R. Robinson.

(1) Ringworm fungus growing upon the mucous membrane; (2) a drawing of a syphilide; (3) an unusual syphilide; (4) primary tuberculosis of the tongue; (5) ordinary warts presented on account of their extent; (6) lichen planus in a negress, the lesions the color of ink; (7) Paget's disease of the nipple; (8) lymphangioma circumscriptum with hæmorrhagic lesions; (9) very rapidly spreading and malignant epithelioma of the face. Three drawings were shown of hereditary keratosis of feet and hands.

Some Cutaneous Affections in the Negro.—Dr. Dyer presented some photographs of unusual conditions in the negro, viz.: (1) Leprosy; (2) keloid following herpes zoster; (3) tinea circinata imbricata; (4) alopecia areata—the only one he had ever seen in a negro; (5) atrophic alopecia due to uncleanliness and suppuration following seborrhœa oleosa; (6) an unusual type of leukoderma in a girl of twelve years.

Dr. Allen presented, on behalf of Dr. Hardaway, two photographs of arsenical pigmentation in children.

Election of Officers.—Dr. James C. White was elected president, Dr. Louis A. Duhring, vice-president, and Dr. John T. Bowen, secretary, for the following year.

Item.

Change in the Editorial and Business Management.—The editor desires to announce that he has disposed of his interest in the Journal of Cutaneous and Genito-Urinary Diseases. Beginning with the new year it will be under the editorial control of Dr. James C. Johnston and Dr. George Knowles Swinburne. The editors will have the active co-operation of the following gentlemen: Louis A. Duhring, M. D., John A. Fordyce, M. D., Edward L. Keyes, M. D., Prince A. Morrow, M. D., Robert W. Taylor, M. D., and James C. White, M. D.

The Journal will be permanently enlarged to forty-eight pages, so that more space may be devoted to abstracts of important original communications on both special subjects. Illustrations will be freely used as heretofore, and in other respects the Journal will be conducted on the same general plan as in the past.

All renewals and subscriptions for the new volume, exchanges, books for review, and all editorial and business communications should be addressed to the acting editor, Dr. James C. Johnston, 115 West Eighty-fourth Street, New York city. All arrears should be sent to D. Appleton & Company, 72 Fifth Avenue.

Special Notice to Exchanges.—Beginning with the new volume for 1897 all exchange journals should be addressed to the acting editor, 115 West Eighty-fourth Street, New York city.

INDEX.

Acne, a new method in local treatment of. James Nevins Hyde, 100.
Acne of neck, treatment of, 228.
Acne, treatment of, 123.
Acute circumscribed œdema of skin in an alcoholic subject, 122.
Alimentary regimen in skin disease, 106.
Alopecia areata in children, 80.
Alopecia areata, new researches on, 366.
 a contagious disease, 366.
 histology of, 367.
 first histological phase of, 368.
 pathogenic theory of, 370.
 some little-known peculiarities in the symptomatology of, 366.
 study of diseased hair in, 366.
Alopeciæ decalvantes, 371.
American Dermatological Association, 438.
 Twentieth annual meeting, 487.
 President's address, Robinson, 438.
Angiokeratoma of scrotum. Raynaud's disease of the ears. Lupus erythematosus disappearing during pregnancy. J. A. Fordyce, 81.
Argonin, 207.
Ashmead, A. S. Evidences in Yucatan as to the possible connection of pre-Columbian syphilis with Asia, 93.
Ashmead, A. S. Prof. Bandelier's views on Huacos pottery and pre-Columbian syphilis, 53.

Bacillus of the peladic utricle, 369.
Bacteriuria. Goldenberg, 324.
Bladder drainage, a new method of. Dawbarn, 194.
Bloom, I. N. Degeneration of the testicle following an injury; operation; recovery, 310.
Book Reviews:
 Cutaneous Medicine. Part I. Louis A. Duhring, 77.
Book Reviews:
 Die Geschichte der venerischen Krankheiten. Von J. K. Proksch, 196.
 Die Histopathologie der Hautkrankheiten. Dr. P. G. Unna, 482.
 Diseases of the Skin. Twentieth Century Practice. Vol. V, 406.
 Disorders of the Male Sexual Organs. Eugene Fuller, 245.
 Epithéliome primitif de l'urèthre. Melville Wassermann, 197.
 Handbook of the Diagnosis and Treatment of Skin Diseases. Arthur van Harlingen, 120.
 International Atlas of Rare Skin Diseases, 77.
 Manual of Syphilis and the Venereal Diseases. James Nevins Hyde and Frank Montgomery 410.
 Organic Materia Medica. John M. Maisch, 328.
 Pathology and Treatment of Diseases of the Skin. Moriz Kaposi, 117.
 Pathology and Treatment of Ve nereal Diseases. R. W. Taylor 116.
 Physical and Natural Therapeutics. George Hayem, 327.
 Syphilis. Alfred Cooper, 411.
 The Histopathology of Diseases of the Skin. By P. G. Unna, M. D. Translated by Dr. Norman Walker, 482.
 Traitement de la Syphilis. Charles Mauriac, 247.
 Yearbook of Treatment, 327.
Bowen, John T. Keratosis follicularis, etc., 209.
Brewer, George E., and Pearce Bailey. Clinical and pathological report of a case of cerebral syphilis, 338. Discussion, 365.

BROWN, F. TILDEN. Case of double ligation of vasa deferentia, etc., 21. Discussion, 32.

Calcium chloride in urticaria, 287.
Calculus, a vesical, of unusual size. Otis, 324.
Calculus, vesical, removed by suprapubic operation. Hayden, 163.
CANTRELL, J. A. An extensive case of tinea cruris, 104.
Case of
alopecia areata. Cutler, 29.
alopecia areata. Sherwell, 399.
angiomata of face. Fox, 354.
atrophy of skin. Jackson, 110.
carcinoma of rectum. Lilienthal, 237.
chancroids about anus. Guiteras, 237.
chronic eczema with cretinism, Klotz, 30.
chylous hydrocele. Brown, 32.
comedo extractor. Allen, 493.
congenital nævus. Cutler, 403.
copaiba eruption. Fordyce, 68, 160.
dislocation of testicle. Guiteras, 36.
double tubercular epididymitis, Alexander, 69.
epidermolysis bullosa. Elliot, 26.
epithelioma treated with injections of toxines of erysipelas. Lewis, 232.
epithelioma. Fox, 31.
erysipeloid. Fordyce, 28.
for diagnosis. Bronson, 352.
for diagnosis. Fox, 29, 63, 157, 231.
Fordyce, 25, 160.
Gibson, 70.
Jackson, 28.
Johnston, 401.
Lustgarten, 157.
Sherwell, 231.
fungating growth of nose and lip. Fox, 112.
lenticular cancer of skin. Lustgarten, 351.
lupus erythematosus. Klotz, 235.
lichen planus. Robinson, 365.
lichen ruber acuminatus. Lustgarten, 113.
mycosis fungoides. Lapowski, 403.
Morrow, 28.
Case of
myxœdema. Lustgarten, 357.
nævus mollusciformis. Fox, 28.
papulo-tubercular syphilide of legs. Klotz, 188.
pityriasis rosea. Fordyce, 355.
rubra. Elliot, 27.
psoriasis. Fox, 160.
pyonephrosis. Guiteras, 36, 71.
rhinoscleroma. Wende, 112.
sarcoma of ear. Sherwell, 162.
tubercular epididymitis, 69.
tumor of testicle. Guiteras, 236.
urethral chancroid. Swinburne, 32.
urethroplasty. Guiteras, 193.
urticaria papulosa Fox, 402.
pigmentosa. Cutler, 235.
vitiligo. Sherwell, 66.
Castration for prostatic overgrowth. Bryson, 318.
Chancre, six cases of labial. E. J. Stout, 391.
Chancre, two cases of urethral, with unusual secondary symptoms. Tuttle, 364.
Chancroid, report of a case of phagedenic. Edward R. Owings, 239.
Chilblains, treatment of, 288.
Classification of diseases of the skin, a pathological and clinical. Duhring, 459.
Chromic acid and nitrate of silver in syphilis and other affections, 80.
Clitoris, primary malignant tumors of, 206.
Colchicum in furunculosis and acne, 208.
Colles' law in a professional nurse, 39.
COLLINGS, H. P. Report of a case of reinfection in syphilis, 308.
Colored drawings, photographs and photomicrographs, exhibition of. Fordyce, 499.
Congress of Dermatology, third international. Programme, 168.
CORLETT, W. T. A peculiar disease of the skin accompanied by extensive warty growths and severe itching, 301.
CORRESPONDENCE :
Cutaneous affections in the negro, photographs illustrating. Dyer, 501.
Dermatology and syphilography in France. Brocq, 37, 106, 241, 366.

CORRESPONDENCE:
Ligation of vasa deferentia. Bransford Lewis, 328.
Proposed congress for the suppression of leprosy. Ashmead-Goldschmidt, 280.
Regulation of prostitution. R. K. Macalester, 72.
Rubber sheet in urethral and vesical irrigation. W. W. Townsend, 74.

Dermatitis, generalized exfoliative, complicated by a multiple cutaneous sarcomatosis, 207.
Dermatitis herpetiformis, relationship of, to erythema multiforme and pemphigus. Duhring, 493.
Dermatitis herpetiformis. George T. Elliot, 150.
Dermatitis venenata, notes on. White, 441.
Diabetes, the cutaneous manifestations of, 284.
Diagnosis of liquid and semi-liquid formations in the inguino-scrotal region. Thomas H. Manley, 250. Discussion, 324.
Dystrophia unguium et pilorum propria. Charles J. White, 220.

Eczema, treatment of, 287.
Eczematous affections and psoriasis, effect of diet and alcohol on causation and course of. White, 449.
Electrolysis for treatment of stricture. Fort, 33.
ELLIOT, GEORGE T. A case of dermatitis herpetiformis, 150.
ELLIOT, GEORGE T. An unusual case of lupus vulgaris, lupus annularis, 476.
Epicystotomy and use of hard rubber stem in treatment of "old man's bladder." W. O. Roberts, 180.
Epididymitis, double tubercular. Hance, 163.
Epithelioma of penis. William L. Rodman, 185.
Epithelioma, primary, of ureter, 122.
Erythema multiforme, 282.
Erythema multiforme exudativum, visceral complications of, 201.
Europhen, 208.
Evidences in Yucatan as to the possible connection of pre-Columbian syphilis with Asia. A. S. Ashmead, 93.

Favuslike eruption of oral mucous membrane caused by aspergillus niger. Winfield, 448.
Folliculitis decalvans, case of. George Thomas Jackson, 264.
FORDYCE, J. A. Angiokeratoma of scrotum. Raynaud's disease of the ears, etc., 81.
FORDYCE, J. A. A peculiar affection of the mucous membranes of the lips and oral cavity, 413. Discussion, 448.
FULLER, EUGENE. Interesting points connected with a nephrectomy secondary to a nephrotomy, 146.
FULLER, EUGENE. Operative interference in aggravated instances of seminal vesiculitis, 329. Discussion, 312.

Genito-urinary tract of a hermaphrodite. Ferguson, 238.
Genito-urinary Surgeons, American Association of. Programme, 248. Transactions, 269, 312, 360.
Glycosuric dermatoses. Allen, 487.
GOLDENBERG, HERMANN. A modified cooling sound in the treatment of prostatitis, 186.
Gonorrhœa, duration of acute. Christian, 321.
formalin in. George T. Howland, 227.
metastases in internal organs. 202.
the use of argonin in the acute stages of. George Knowles Swinburne, 289.
treatment of, with argentum-casein, 167.
Gonorrhœal urethritis, the method of irrigation in. O. J. Stein, 102.
GRAHAM, J. E. Hydroa æstivale, 41.

HORWITZ, ORVILLE. Complete extirpation of the penis for epithelial carcinoma, 305.
HORWITZ, ORVILLE. Hydrocele, its radical cure, 343.
HOWLAND, G. T. Formalin in gonorrhœa, 227.
HYDE, J. N. A new method in the local treatment of acne, 100.
HYDE, J. N., NICHOLAS SENN, and D. D. BISHOP. A contribution to the study of mycetoma in America, 1.
Hydroa æstivale. James E. Graham, 41.

Hydrocele—its radical cure. Orville Horwitz, 343.
Hypertrophic rosacea (pachydermatosis) resembling tubercular leprosy, cured with thyroid extract. Dyer, 491.
HUTCHINS, M. B. A case of porokeratosis (Mibelli), 373.

Ichthyol in burns, 80.
Impetigo contagiosa universalis. Allen, 497.
Impetigo contagiosa annulata et serpiginosa. Jay F. Schamberg, 169.
Infected scratch and its relation to impetigo and ecthyma. Hermann G. Klotz, 46.
Infectious diseases, treatment of, 121.
Injections of insoluble mercurial compounds, 241.
 of soluble mercurial compounds, 241.
 of insoluble mercurial compounds, indications for, 242.
Insoluble mercurial compounds, contraindications to employment of, 244.
Insoluble mercurial used, choice of, 244.
Intertrigo, chromic acid in, 412.
Intravenous injections of bichloride of mercury, 123.
Iodic eruptious, prophylaxis of, 287.
Iodide, question of potassium, 244.
Iodides other than those of potassium in the treatment of syphilis, 287.
Iodine in onychomycosis, 208.
Iodoform, eruption from local use of. Fordyce, 499.
Ischuria, some forms of nonobstructive. Stein, 317.

JACKSON, G. T. A case of Paget's disease of nipple, 428. Discussion, 443.
JACKSON, G. T. A case of folliculitis decalvans, 264.
Janet's sterilizable syringes. Van der Poel, 237.
JOHNSTON, J. C. Bullous quinine dermatitis, 266.

Keratosis follicularis. Psorospermose folliculaire végétante, Darier, apropos of a new case. John T. Bowen, 209.
Kidney, a, with anomalous blood supply. Fuller, 238.
Kidney and ureter, an anomalous. Dawbarn, 324.
Kidney, movable; its frequency, etc. Watson, 275.
KLOTZ, HERMANN G. Infected scratch aud its relation to impetigo and ecthyma, 46.

Local anæsthesia in dermatology, 109.
Local changes from intramuscular injections of insoluble mercurial preparations, 203.
Lupus vulgaris, lupus annularis, an unusual case of. George T. Elliot. 476.

MANLEY, T. H. The diagnosis of liquid and semi-liquid formations in the inguino-scrotal region, 254. Discussion, 324.
MASTIN, C. H. President's address before the tenth annual meeting of the American Association of Genito-Urinary Surgeons, 249, 269.
Molluscum contagiosum, controversy as to the nature of changes in, 204.
Morphea, a case of symmetrical, etc. Prince A. Morrow, 419. Discussion, 446.
MORROW, P. A. A case of symmetrical morphea with the formation of bullæ and extensive ulceration, 419.
MORROW, P. A. Notes on syphilis, etc., 125.
Mucous membrane of lips and oral cavity, a peculiar affection of. John A. Fordyce, 413. Discussion, 448.
Mycetoma of the foot as it occurs in America, a contribution to the study of. James Nevins Hyde, Nicholas Senn, and D. D. Bishop, 1.
Mycosis fungoides, more especially the pre-fungoidal stage. Clinical history of two cases. Prince A. Morrow, 455.
Mycosis fungoides and sarcomatosis cutis. Bowen, 456.

Nævus unius lateris, an unusual case of. Charles C. Ransom, 141.
Nephrectomy secondary to nephrotomy, interesting points connected with. Eugene Fuller, 146. Discussion, 165.
Neurodermitis, parasitophobic, 284.
New York Academy of Medicine. Section on Genito-Urinary Surgery, 32, 69, 114, 163, 193, 236, 322.

New York Dermatological Society, 25, 63, 110, 157, 188, 231, 351, 399.
Nose, red, treatment of, 288.
Nosophen, 208.

Oidium, an, in the tissues of a case of pseudo-lupus vulgaris, 464.
OWINGS, E. R. Report of a case of phagedenic chancroid, 229.

Paget's disease of the nipple, a case of. George T. Jackson, 428. Discussion, 443.
Penis, complete extirpation of, for epithelial carcinoma. Orville Horwitz, 305.
Perfected metro-urethrotome and other instruments. Brown, 72.
Phlegmonous and suppurative inflammation following vaccination, the vaccination erysipelas of authors. Theodore W. Schaefer, 396.
Photographs, exhibition of. Morrow, 500. Robinson, 501.
Plasma cells in normal hematopoietic organs, 205.
Polymyositis acuta, 285.
Porokeratosis (Mibelli), a case of. M. B. Hutchins, 373.
President's address before the tenth annual meeting of the Association of Genito-Urinary Surgeons. Claudius H. Mastin, 249, 269.
Prostate, an instrument for massage of. Swinburne, 195.
castration in hypertrophy of, 198.
Prostate gland, some acute and chronic conditions of. Bangs, 165.
specimen of, after double castration. Kelsey, 164.
Prostatectomy on a monorchid. Bryson, 318.
Prostatitis, a modified rectal cooling sound for treatment of. Hermann Goldenberg, 186.
Pruritus, scrotal, picric acid in, 288.
Psoriasis in early childhood, 122.
Psoriasis treated by mercurial injections, 39.
Purpura hemorrhagica, the relationship of, to erythema multiforme, 282.
Purpura, senile, 283.
Purpuric eruption, a remarkable case ending in gangrene, apparently caused by sodium salicylate. Francis J. Shepherd, 16.
Pyelitis, treatment of, with irrigation, 199.
Pyrogallol intoxication, 122.

Quinine dermatitis, bullous. James C. Johnston, 266.

RANSOM, C. C. An unusual case of nævus unius lateris, 141.
Rapid efficacy of subcutaneous injections of calomel in tertiary laryngitis, 40.
Renal tuberculosis. Brown, 313.
Resection of vasa deferentia in hypertrophy of the prostate, 122.
Rhinoscleroma, a case of, originating in the United States. Grover W. Wende, 90.
ROBERTS, W. O. Epicystotomy, etc., 180.
RODMAN, W. L. Epithelioma of penis, 185.
Rupture of urethra treated by external urethrotomy and suture. Cabot, 269.

Sarcoma, generalized idiopathic, with giant cells, 283.
SCHAEFER, T. W. Phlegmonous and suppurative inflammation following vaccination, the vaccination erysipelas of authors, 396.
SCHAMBERG, J. F. Impetigo contagiosa annulata et serpiginosa, 169.
Seminal vesicles, morphology of. Huntington, 196.
Seminal vesiculitis, operative interference in aggravated instances of. Eugene Fuller, 329. Discussion, 312.
Serotherapy in urinary infection, 411.
SHEPHERD, F. J. A remarkable case of purpuric eruption, etc., 16.
Skin, a peculiar disease of, accompanied by extensive warty growths and severe itching. William T. Corlett, 301.
STEIN, O. J. The method of irrigation in gonorrhœal urethritis, 102.
STONE, E. J. Six cases of labial chancre, 391.
Stricture, management of filiform, of the urethra, with some observations on stricture. J. D. Thomas, 173.
Suppurative and pemphigoid disease of the skin, a new form of, 283.
SWINBURNE, G. K. The use of argonin in acute cases of gonorrhœa, 289.
Syphilis, alterations in blood in, 200.
clinical and pathological notes on. J. A. Fordyce, 365.

Syphilis, clinical and pathological report of a case of cerebral. George E. Brewer and Pearce Bailey, 338. Discussion, 365.
common treatment of. Greene, 238.
notes on. P. A. Morrow, 125.
post-conceptional. Post, 360.
Prof. Bandelier's views on Huacos pottery and pre-Columbian. A. S. Ashmead, 53.
question of injection of mercurial compounds in treatmant of, 241.
report of a case of reinfection of. Howard P. Collings, 308.
Syphilis, serum injections in secondary, 80.
treatment of, 288.

Technique of amputation of penis. Guiteras, 114.
Testicle, degeneration of, following injury; operation; recovery. I. N. Bloom, 310.
Therapeutic notes, 80, 207, 287, 411.
Thioform, 124.
THOMAS, J. D. Management of filiform stricture of the urethra, 173.
Thyroid in lupus, 80.
in psoriasis and vitiligo, 208.
Tinea cruris, an extensive case of. J. Abbott Cantrell, 104.
Tinea favosa epidermidis, an interesting case of. G. W. Wende, 383.
Treatment of hypertrophic acne at the beginning, 37.
Treatment of pelvic complications of gonorrhœa in women. Pryor, 32.
Tuberculosis, cutaneous, cured by potassium cantharidate, 412.

Urethra, capacity of, 286.
congenital occlusion of. Allen, 322.
Urethral resection, good results following. Fuller, 273.
Urethrectomy, two cases of, with transplantation for urethral strictures. Bryson, 273.
Urinary diseases in women, 285.
Urine, membranes of bacteria in, 286.

Vasa deferentia, case of double ligation of, for hypertrophy of prostate. F. Tilden Brown, 21. Discussion, 32.
Vas deferens, primary union after suture of, 206.
Vesical and other injections, poisonings by, 205.
Vesical calculi removed by suprapubic cystotomy. Taylor, 195.

WENDE, G. W. A case of rhinoscleroma originating in the United States, 90.
WENDE, G. W. An interesting case of tinea favosa epidermidis, 383.
WHITE, CHARLES J. Dystrophia unguium et pilorum propria, 220.
WIGGLESWORTH, Dr. EDWARD. Item, 124.

Xanthoma diabeticorum. Robinson, 490.

CONTRIBUTORS TO VOL. XIV.

ASHMEAD, ALBERT S.
BAILEY, PEARCE.
BISHOP, D. D.
BLOOM, I. N.
BOWEN, J. T.
BREWER, GEORGE E.
BROWN, F. TILDEN.
CANTRELL, J. A.
COLLINS, H. P.
CORLETT, W. T.
ELLIOT, G. T.
FORDYCE, J. A.
FULLER, EUGENE.
GOLDENBERG, HERMANN.
GRAHAM, J. E.
HORWITZ, ORVILLE.
HOWLAND, G. T.
HUTCHINS, M. B.
HYDE, J. N.
JACKSON, G. T.
JOHNSTON, J. C.
KLOTZ, HERMANN G.
MANLEY, T. H.
MASTIN, C. H.
MORROW, P. A.
OWINGS, E. R.
RANSOM, C. C.
ROBERTS, W. O.
RODMAN, W. L.
SCHAEFER, T. W.
SCHAMBERG, J. F.
SENN, NICHOLAS.
SHEPHERD, F. J.
STEIN, O. J.
STOUT, E. J.
SWINBURNE, G. K.
THOMAS, J. D.
WENDE, G. W.
WHITE, C. J.

COLUMBIA UNIVERSITY LIBRARY

This book is due on the date indicated below, or at the expiration of a definite period after the date of borrowing, as provided by the rules of the Library or by special arrangement with the Librarian in charge.

DATE BORROWED	DATE DUE	DATE BORROWED	DATE DUE
	JUL 29 '40		
C28(239)M100			